KENTUCKIANA
COURT REPORTERS

CASE NO: 20-CV-1123

GREGORY BOYER, AS ADMINISTRATOR OF THE ESTATE OF CHRISTINE BOYER, AND ON HIS OWN BEHALF

V.

ADVANCED CORRECTIONAL HEALTHCARE, INC., ET AL.

DEPONENT:

LISA PISNEY

DATE:

MARCH 3, 2022

IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

JUDGE JAMES D. PETERSON

MAGISTRATE JUDGE STEPHEN L. CROCKER

CASE NO: 20-CV-1123

GREGORY BOYER, AS ADMINISTRATOR OF THE ESTATE OF CHRISTINE BOYER, AND ON HIS OWN BEHALF,

Plaintiff,

V.

ADVANCED CORRECTIONAL HEALTHCARE, INC., ET AL.,

Defendants.

DEPONENT: LISA PISNEY

DATE: MARCH 3, 2022

REPORTER: SYDNEY LITTLE

APPEARANCES

ON BEHALF OF THE PLAINTIFF, GREGORY BOYER, AS ADMINISTRATOR OF THE ESTATE OF CHRISTINE BOYER, AND ON HIS OWN BEHALF:
Stephen H. Weil, Esquire
Loevy & Loevy
311 North Aberdeen
3rd Floor
Chicago, Illinois 60607
Telephone No.: (312) 243-5900
E-mail: weil@loevy.com
(Appeared via videoconference)

ON BEHALF OF THE DEFENDANT, LISA PISNEY, AMBER FENNIGKOH, ADVANCED CORRECTIONAL HEALTHCARE, INC.:
Douglas S. Knott, Esquire
Leib Knott Gaynor LLC
219 North Milwaukee Street
Suite 710
Milwaukee, Wisconsin 53202
Telephone No.: (414) 276-2109
E-mail: dknott@lkglaw.net
(Appeared via videoconference)

APPEARANCES (CONTINUED)

ON BEHALF OF THE DEFENDANT, MONROE COUNTY, SHASTA PARKER, DANIELLE WARREN, STAN HENDRICKSON:
John McCauley, Esquire
Hansen Reynolds LLC
10 East Doty Street
Suite 800
Madison, Wisconsin 53703
Telephone No.: (608) 841-1510
E-mail: jmccauley@hansenreynolds.com
(Appeared via videoconference)

INDEX

EXHIBITS

STIPULATION

The VIDEO deposition of LISA PISNEY was taken at KENTUCKIANA COURT REPORTERS, 730 WEST MAIN STREET, SUITE 101, LOUISVILLE, KENTUCKY 40202, via videoconference in which all participants attended remotely, on THURSDAY the 3rd day of MARCH 2022 at 10:20 a.m.; said deposition was taken pursuant to the FEDERAL Rules of Civil Procedure. The oath in this matter was sworn remotely pursuant to FRCP 30.

It is agreed that SYDNEY LITTLE, being a Notary Public and Court Reporter, may swear the witness.

PROCEEDINGS

COURT REPORTER: On record. My name is Sydney Little. I'm the online video technician and court reporter today representing Kentuckiana Court Reporters, located at 730 West Main Street, Suite 101, Louisville, Kentucky 40202. Today is the 3rd day of March 2022. The time is 10:21 a.m. We are convened by video conference to take the deposition of Lisa Pisney, in the matter of Gregory Boyer as Administrator of the Estate of Christine Boyer, and on his own behalf versus Advanced Correctional Healthcare, Inc., et al., pending in the United States District Court for the Western District of Wisconsin, case number 20-CV-1123. Will everyone, but the witness, please state your appearance, how you're attending, and the location you're attending from, starting with plaintiff's counsel?

MR. WEIL: Good morning. My is Stephen Weil. I'm with the firm Loevy & Loevy. I represent the plaintiff. I'm attending via video from Chicago, Illinois.

MR. MCCAULEY: Good morning. I'm John McCauley, with the Hansen Reynolds law firm. I'm appearing by video from Madison, Wisconsin. I

represent Monroe County and Stan Hendrickson, Shasta Parker, and Danielle Warren.

MR. KNOTT: I'm Doug Knott from the law firm of Leib Knott Gaynor in Milwaukee. I represent Advanced Correctional Healthcare, Ms. Pisney, and Ms. Fennigkoh, and I'm at the Milwaukee County Sheriff's Office in Sparta.

THE WITNESS: Monroe County.

MR. KNOTT: What?

THE WITNESS: You said Milwaukee. It's Monroe County, right?

MR. KNOTT: Right. Okay.

THE WITNESS: All right. Thank you very much.

MR. KNOTT: I don't know what I said, but we're all here.

COURT REPORTER: Ms. Pisney, please state your name for the record.

THE WITNESS: Lisa Pisney.

COURT REPORTER: Do all parties agree and stipulate that the witness is, in fact, Lisa Pisney?

MR. KNOTT: Yes.

MR. WEIL: Plaintiff stipulates.

COURT REPORTER: Thank you. Ms. Pisney, will you please raise your right hand? Do you solemnly

swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

COURT REPORTER: Thank you. Counsel, you may begin.

DIRECT EXAMINATION

BY MR. WEIL:

Q Ms. Pisney, good morning. My name is Stephen Weil. I represent the plaintiff, as you've just heard. Have you ever been deposed before?

A No.

Q I expect that your Counsel talked to you about how to sit for a deposition. There are several rules that make this different from a normal conversation. You understand that you're under oath today; is that right?

A Yes.

Q And your answers that you give at this deposition will have the same effect, as if they were in a court of law, do you understand that?

A Yes. I am -- I understand.

Q The perhaps the most important rule of the deposition is that, unlike normal conversations that you have out in the world, this conversation is being taken down by a court reporter. That means that it's

important for the two of us not to talk over each other. It's natural for people to anticipate answers and questions. In normal conversation, that's not rude. It's just something that happens, but a court reporter cannot take down two people talking at the same time. I, therefore, ask that you wait until I'm finishing with my -- I've finished with my question before you answer it, and I'll do my best to wait for you to finish your answer before I ask another question, does that make sense?

A Yes.

Q The lawyers may object from time to time in this deposition. That's part of preserving legal rights in the case, but you must still answer the questions that I ask you unless your lawyer instructs you not to, does that make sense?

A Yes.

Q Okay. You should keep your answers verbal and audible. Shakes of the head and uh-huh are hard to record on a transcript, even though we do have a video, does that make sense?

A Yes.

Q Okay. You're entitled to take breaks during this deposition. It's not an endurance test. I would ask that before you take a break, you answer any

Page 10

questions pending, does that make sense?
A Yes.
Q There are rules governing when you can talk to your lawyers during the course of a deposition. And I reserve the right to ask you about any discussions you had with your lawyer during a break, does that make sense?
A Yes.
Q Do you have any conditions that might affect your ability to provide truthful and accurate testimony today?
A No.
Q Any conditions affecting your memory or any medications that you might be on, that might affect your ability to provide truthful and accurate testimony?
A No.
Q Where do you currently work?
A I work for UnityPoint out of Waterloo and I work at the John Deere Waterloo Works as their occupational health nurse practitioner.
Q What is UnityPoint?
A It's a health conglomerate that owns a hospital in multiple places. They have --
Q You said you work in -- I'm sorry. I broke the rule already. Go ahead.

Page 11

A They have multiple hospitals that they own and manage.
Q Which hospital did you say you worked at?
A I work actually at John Deere. I work through UnityPoint at work. And I'm a occupational health nurse practitioner who resides in the Waterloo Works John Deere facilities, and takes care of their occupational health.
Q So if I understand you correctly, you work for a company called UnityPoint, but you are -- you work at a John Deere plant; is that right?
A Yes. Yes. That's correct.
Q And you service -- okay. And you service the employees at the John Deere plant?
A Yes. If they're injured at work. Yes.
Q Okay. Did Christine Boyer have a serious medical condition?
MR. KNOTT: Object to form of the question, to the extent it calls for a legal conclusion. Object, it's vague as to time and it's vague as to the phrase itself. You can answer, if you're able.
A It's hard for me to know. We didn't know her full medical history.
BY MR. WEIL:
Q Sitting here today, do you believe that

Page 12

Christine Boyer had a serious medical condition, while she was in the jail?
MR. KNOTT: Object to the form of the question, vague as to time. Object to the extent it calls for legal conclusion. It's also vague as to the phrase, "Serious medical condition." Counsel, could you specify a time frame?
MR. WEIL: Just like I said, "While she was in the jail."
A Not the entire time she was in the jail, I don't believe so.
BY MR. WEIL:
Q Okay. What -- at what time during the time she was at the jail, did Christie Boyer have a serious medical condition?
MR. KNOTT: Same objections.
A When -- when she coded. That was a serious medical condition.
Q Any other time?
MR. KNOTT: Same objections.
MR. MCCAULEY: Joined.
A Prior to that, I don't believe she -- I had any indication that she had a more serious condition.
Q Sitting here today, do you believe that she did have a serious medical condition, before she coded?

Page 13

MR. KNOTT: Counsel, could you specify a period of time?
MR. WEIL: During the time she was at the jail.
MR. KNOTT: Object to the form of the question. And same objections as stated previously.
A Can -- can you ask me the question again? I'm sorry.
BY MR. WEIL:
Q During the time she was at the jail, before she coded, did Christine Boyer have a serious medical condition?
MR. KNOTT: Same objections. Add to it that it calls for speculation.
MR. MCCAULEY: Joined.
A From what I knew about her, I did not think she had a serious medical condition prior to that.
BY MR. WEIL:
Q Sitting here today, what do you believe?
MR. KNOTT: Same objections.
A That -- that would require me to know things now that I didn't know then.
Q Given what you know now, what do you believe?
MR. MCCAULEY: Object to form. Foundation.

Page 14

MR. KNOTT: Yeah. Same objections as previously stated.

A I mean, everyone else knows more in hindsight. I mean, I've gotten more information about her medical condition since the -- since her entry into the jail.

BY MR. WEIL:

Q And given the information you've received, what do you believe now?

MR. KNOTT: Same objections. And vague as to time. It's also irrelevant, but answer if you're able.

A I still don't have all the information about her medical history. I mean, if -- it's obvious that if someone codes, that they had a serious medical condition.

Q Do you believe that Christine Boyer received adequate medical treatment at the jail in December 2019?

A I do.

Q Why is that?

MR. MCCAULEY: Object to form.

A I believe that we treated her appropriately with the information that we had at the time.

Q When you say we, who are you referring to?

A Myself, the other nurse, and the correctional officers.

Page 15

Q Do you have an independent memory of Christine Boyer? I understand that you never -- you never met Christine Boyer, right?

A Right. I never met her in person. No. I do remember.

Q Do you have an independent -- go ahead. I'm sorry.

MR. KNOTT: She wasn't finished.

A I'm sorry. I do remember the case.

Q Okay. When I say independent memory, do you understand that I mean, what you can remember without looking at documents?

A Yes.

Q So do you have an independent memory of the events involving Christine Boyer at the jail in December 2019?

A I do.

Q What do you recall about those events? And I would ask you just to start from -- go chronologically.

A Okay. I believe I talked to Amber, the jail nurse, about her intake, the fact that we were not able to get her medicines. She wasn't able to give us any information about the medications she took or her complete medical history, that it was very vague what she gave during intake. And then later in the day, I

Page 16

was called with an elevated blood pressure for her. We treated her with medications for the elevated blood pressure. I asked them to recheck her blood pressure in half an hour and call me back. That was done. They then -- I then asked them to recheck again in an hour, and if the blood pressure was above 160 over 100, to give another medication. And then I believe they called me later that day -- or that evening with some complaints of chest pain. We talked about that. I gave her aspirin, and asked them to recheck her blood pressure in a half an hour, and call me if it was elevated or if she continued to complain of chest pain. And after that, I never received a call back.

Q Is that all you remember from Christine Boyer's time at the jail?

A Yes.

MR. KNOTT: Object. It's vague and overly broad.

Q That was a yes?

A That was yes. Yes.

Q Okay. I want to go through events that you described just now. The first thing you said was that you talked to Amber, the jail nurse, do you remember that?

A I believe so. Yeah. I remember it as talking

Page 17

to Amber.

Q Do you remember when that conversation occurred?

A I do not.

Q Was it in the middle of the night or during the day?

A I believe it was during the day.

Q You're aware that Christine Boyer was at the jail -- she came into the jail on December 21st in the evening, was there during the day on Sunday, December 22nd, and then coded shortly after midnight on Monday, December 23rd?

A I don't remember those specific dates, but that correlates with the paperwork I've seen.

Q Okay. Without remembering the dates, you remember being contacted over the course of a fairly short period about Christine Boyer, several times, right?

A Yes.

Q Okay. And so, again, your first memory, the first event you talked about was talking to Amber; is that right?

A Correct.

Q And that's Amber Fennigkoh?

A Correct.

Page 18

Q And do you remember that, that conversation was during the day?

A I believe so.

Q Okay. Do you remember approximately what time you had that conversation?

A No. I don't have any memory of that.

Q You talked -- you said later in the day -- the next thing after talking to Amber, what I have in my notes, is you said later in the day you received a call about high blood pressure; is that right? That's what you recall?

A Correct.

Q So you would have spoken with the person you believed to be Amber, sometime before getting the call about high blood pressure?

A Yes.

Q Okay. And there were -- was it two calls about high blood pressure?

A Yes. I believe so.

Q Okay. Do you recall any other symptoms being mentioned during those two calls?

A No. I don't.

Q Okay. And then you received -- you recall receiving one call later on about chest pain?

A Correct.

Page 19

Q What was -- after receiving that call about chest pain, what was -- the next time you heard anything about Christine Boyer?

A I -- the next day I did -- it was my day to visit the jail on Monday and when I went in to see Amber that day, I asked how she was doing. And that's when Amber told me that she had coded, and was in the hospital.

Q Okay. So you physically went to the jail on Monday; is that right?

A Correct.

Q Did you -- in the time that you recall Ms. Boyer being at the jail, did you place any calls relating to Ms. Boyer?

A No.

Q When you received the call in the -- well, to back up real quick. I want to go to the first call you recall speaking with Amber. You -- I have in my notes here, you're saying two things. One is that you were not able to get the meds -- that she was not able to get the meds for Ms. Boyer; is that right?

A Right. So we -- she was unable to tell Amber what medication she was taking. At some point, someone must have called and ran through the medications that she had on her person. And I okayed or denied the use of those medications, according to the paperwork I -- I've seen.

Q Is this an additional call, besides the call with Amber Fennigkoh, is this is a separate call that you're referring to?

A I don't know if Amber discussed those with me at that time, or if I received another call from one of the correctional officers about okaying those medications.

Q Okay. So if I understand you right, you recall receiving either one or two calls in -- before a call later in the day about high blood pressure; is that right?

A I mean, I only remember one call, but --

Q Okay.

A -- it could have been two.

Q Okay. It could have been -- it could have been one call from Amber Fennigkoh or it could have been a call from Amber Fennigkoh and somebody else -- and a second call from somebody else?

MR. KNOTT: Wait a minute. I think you're discussing different calls.

MR. WEIL: Yeah. I am. I'll get there, Doug. I think I can clear it up.

BY MR. WEIL:

Page 21

Q So one call you remember is from Amber Fennigkoh, and one of the things that Am -- you recall Amber Fennigkoh telling you, is that she was unable to get a full list of medications from Ms. Boyer; is that right?

A Correct.

Q Okay. Do you recall being told about any medications that Amber Fennigkoh, or whoever called you that morning, was able to -- that medication list that she was able to get?

A I don't recall that phone call, but I do see on the paperwork that some of the medications were okay to give and some were not. And so I'm assuming that they called me, and got the -- that okay.

Q Right. So that's fair and I do want to talk to you about what's written on the documents, Ms. Pisney. Right now, I'm just trying to get your independent recollection. So setting aside the documents.

A Okay.

Q I'm just trying to get your independent recollection. So you -- again, to return, you recall receiving a phone call -- just I'm going back to this phone call from Amber Fennigkoh that you recall receiving. And in my notes, I have two issues that were

Page 22

discussed in the call. One, was an inability to get a full medication list or a prescription list. And the other was an inability to get a complete medical history; is that right?

A That is right.

Q Okay. And regarding that call, again, I just want to return to what do you recall in terms of inde -- what independent recollection do you recall -- do you have of what medications were identified -- or what prescriptions were identified at that point?

A I don't recall that at all.

Q Okay. And regarding the medical history, do you have any independent recollection of what medical history you did get on that call?

A I do remember that I was told that Ms. Boyer had said she was -- she had some sort of cancer, and that she was told she only had a month to live, and that was really the only medical history that she relayed.

Q Those were the two things you recall receiving -- you reme -- those the two conditions that you recall?

A Yeah. That -- in my independent recollection. Yes.

Q Okay. And then I believe you said you may have received a second call -- again, I -- this is before the high blood pressure calls?

Page 23

A Right.

Q You may have received a second call about a medication list or medications that were found with Ms. Boyer; is that right?

MR. KNOTT: Object to form.

Q You can answer it.

A That's correct because -- that's correct just because I've seen the -- the MAR, the medical administration. And there are some medications that were denied and some medications that were okayed, and that would have been my responsibility to do that.

Q Understood. And, again, I don't want to -- I'm just trying to get your independent recollection.

A Uh-huh.

Q So setting aside what you saw in documents, in preparation for the -- that you reviewed in preparation for this deposition, do you have an independent recollection of what was discussed on the second call

MR. KNOTT: Object to form.

A No. No. I don't. Sorry.

Q Okay. And, again, the independent recollection being not what you're looking at on documents. But do you have an independent recollection of this call number one, call number two being two separate calls or one single call?

Page 24

A I don't recall.

Q Okay. In other words, to the best of your independent recollection, it may have been one single call or it may have been two different calls; is that right?

A That's possible. I only remember one.

Q Okay. Do you remem -- do you have an independent recollection of approving or denying medications?

A I don't remember doing that. But, again, that would have been my responsibility.

Q Do you have an independent recollection of learning about any medications that Ms. Boyer was found with or that she told anyone about?

A The medications that were on the MAR would have been the medications that were found on her person. And -- and I can't remember if I received that information before or after I saw Amber on Monday. So it's confusing in my memory, when I exactly learned about it. I'm assuming I learned about the medication she had on person, and approved those based on the documents I've reviewed. But I don't remember that in my independent memory.

Q Okay. So you don't -- you are dis -- you were describing a medication list that you saw, but you don't

Page 25

have an independent memory of reviewing or approving those medications; is that right?

A I do not.

Q Okay. I want to go to the call that you described about high blood pressure now -- and that you said it was just later. Do you have a recollection of what time of day you received the call?

A I don't have an independent recollection, just from the paperwork that I've reviewed.

Q Okay. And, again, an independent recol -- your independent recollection. Do you have an independent recollection of what conditions were identified, on that first call about high blood pressure?

A Just the high blood pressure.

Q Okay. Do you have an independent recollection of anything else -- any other symptoms being described for Ms. Boyer?

A Not during that call. No.

Q Okay. And you do have a recollection of a second call about high blood pressure as well; is that right?

A In my independent recollection, I only remember two calls. But in looking at the paperwork, it did bring up a memory of that second call about the

Page 26

blood pressure.

Q When you say, that you have a memory of only two calls, are you talking about over the whole course of the day or two calls about blood pressure?

A Two calls about symptoms that she had. One about the blood pressure, and then the later call about the chest pain.

Q Okay. All right, it sounds like then, you have an independent recollection of three calls. One about -- from Amber Fennigkoh first, a second call about blood pressure, and a third call about chest pain; is that right?

MR. KNOTT: I object. I think it misstates her testimony. I think she said that review of documents helped her.

MR. WEIL: Yeah. I -- yeah. I understand.

BY MR. WEIL:

Q I'm just trying to get your independent recollection, Ms. Pisney. I understand that the documents may have provided you more information. I'm just trying to get your independent recollection. So is that right, you have an independent recollection of three calls?

MR. KNOTT: Object to the form of the question. It misstates her testimony.

Page 27

Q Was your -- well, how many calls do you independently recall receiving about Ms. Boyer while she was at the jail?

A I do remember talking with Amber about her and then the two calls from the COs about her symptoms, so that --

Q And -- go ahead.

A -- would be three.

Q Okay. And one of those calls from COs was about blood pressure and the second call was about chest pain; is that right?

A Correct.

Q Okay. Going to the third call about chest pain that you have an independent recollection of, what do you recall being told about Ms. Boyer's symptoms -- what's your independent recollection about what you were told about Ms. Boyer's symptoms?

A They told me that she had complaints of chest pain, and I asked if she had any other symptoms such as diaphoresis, any shortness of breath. They told me she was not diaphoretic. She may have had some slight shortness of breath, and that's all I remember.

Q What is diaphoresis?

A Sweating.

Q So they -- you -- what you recall is they told you about chest pain. You asked about other -- you asked whether Ms. Boyer had diaphoresis and -- which is sweating and they -- and you were told, no, correct?

Page 28

A Correct.

Q And, again, this is all your independent recollection. I'm not going farther than that right now. And then the other thing that you independently recall asking, is whether Ms. Boyer had shortness of breath; is that right?

A Correct.

Q And your recollection is that -- I don't want to put words in your mouth. What was your recollection of the response to your question about shortness of breath?

A That she may have had some slight shortness of breath. They also would have -- they also gave me her other vital signs besides her -- so blood pressure, heart rate, oxygen saturation.

Q Is that based on your independent recollection about something that happened or is that based on your reading of the documents?

A No. That -- that would have been my independent recollection.

Q Okay. So you independently recall receiving information about Ms. Boyer's blood pressure?

Page 29

A Yes.

Q You independently recall receiving information about Ms. Boyer's heart rate?

A Correct.

Q Okay. And you independently recall information about oxygen saturation?

A Yes.

Q Okay. Anything else -- any other information you in independently recall receiving, on that call about chest pain?

A I do not.

Q What was Ms. Boyer's blood pressure reported to you as?

A That I -- I couldn't independently recall. I remember that it was slightly elevated, but not as elevated as it had been previously in the day.

Q How about her heart rate, do you have an independent recollection of what that was?

A I remember that being normal.

Q Okay. What's normal?

A In the 60 to 80 range.

Q How about her oxygen saturation, what's your recollection of that?

A I also recall that being normal.

Q Okay. Do you have -- beyond the symptoms and

Page 30

the vitals that we've just discussed, do you have a independent recollection of anything -- other information that you were provided, on the call about chest pain?

A I do not.

Q Okay. You mentioned having a recollection of providing some instructions on that call; is that right?

A Yes.

Q What were the instructions that you recall providing, on that third call about chest pain?

A So during that call, I remember the CO saying, could we give her some aspirin? And I said, yes. That would be fine, it wouldn't hurt anything. And that after they gave her the aspirin, to recheck her blood pressure again in a half an hour since it was slightly elevated. And to call me if it was elevated, and also to call me if she continued to have any complaints of chest pain.

Q Okay. So you -- I'm sorry, you recall -- I was writing down. You recall having them check her blood pressure in half an hour -- or asking them to check?

A Yes.

Q Okay. Do you recall instructing the guards about what measurement would constitute elevated blood

Page 31

pressure?

A I do not.

Q Okay. Okay. Do you recall any other information or instructions that were exchanged on that third chest pain call?

A That third call was about chest pain, but the other calls weren't about chest pain. But, no. I do not remember any other instructions.

Q Okay. Tell me everything you did to prepare for today's deposition?

A I looked over the records from the care of Ms. Boyer. I got out my orientation paperwork from ACH. That was -- that was it.

Q You reviewed -- the orientation work; what was that?

A Just the training that I had at ACH, when I first started with them.

Q Okay. And that was training that you received in Peoria, Illinois?

A Correct.

Q And did you retain documents -- or, did you receive documents during that training?

A Yes.

Q Did you retain them?

A Yes.

Page 32

Q And are those -- when you said you reviewed the orientation paperwork, is that what you're referring to -- the documents that you retained?

A Yes.

Q Okay. And then in terms of the --

MR. KNOTT: To be clear, Counsel, you have those.

MR. WEIL: Yeah.

MR. KNOTT: Okay.

BY MR. WEIL:

Q In terms of the treatment paperwork that you reviewed, do you remember what -- can you describe what paperwork you reviewed -- or the treatment documents you reviewed about Ms. Boyer?

MR. KNOTT: Counsel, I could give you the Bates numbers if you'd like?

MR. WEIL: Do you -- how about exhibit numbers? I guess Bates numbers, if you have stuff that's not exhibits, that'd be helpful.

MR. KNOTT: Yeah.

MR. WEIL: Either way is fine.

MR. KNOTT: Materials -- the -- yeah. She did not review anything with exhibit numbers on them, but they were within the materials she did review -- or some exhibits were.

Page 33

MR. WEIL: Okay.

MR. KNOTT: The pages she was given to review were Monroe County, 50 to 110. And Monroe County, 1088 to 1111. As well as the DOC report, 197 to 206.

MR. WEIL: Okay. Is that all, Doug?

MR. KNOTT: Yes.

BY MR. WEIL:

Q Okay. Beyond reviewing the documents that we've just discussed, Ms. Pisney, what else did you do to prepare for this deposition?

MR. KNOTT: Mr. Weil, I need to pause you for a second. I think that we sent her the e-mail that Shasta Parker testified about. And it was not in those materials, in the pages that I referenced. It's the 6:00 p.m. e-mail from Parker to Amber and others.

MR. WEIL: Okay.

MR. KNOTT: Yeah.

BY MR. WEIL:

Q Okay. Go ahead. Ms. Pisney, besides reviewing the documents that we've just gone over, what else did you do to prepare for today's deposition?

A Just meeting with my lawyer to talk about giving testimony in a deposition.

Page 34

Q When did you do that?
A Last night.
Q Any other time besides last night?
A We spoke on the phone last week.
Q So you spoke with your lawyer last night and last week about this deposition, right?
A Correct.
Q And besides speaking with your lawyer on those two occasions, and reviewing the paperwork discussed, did you do anything else?
A No.
Q Other than your attorneys, who else did you speak with about your deposition here today?
A No one.
Q Okay. Other than your attorneys, have you spoke with anybody about Ms. Boyer?
A No. Just right after the -- the incident, I spoke with Amber.
Q Okay. Anybody else?
A No.
Q Do you recall speaking with Travis Schamber?
A Oh, yes. Yeah. I did talk to Dr. Schamber. Correct.
Q Anybody else?
A I talked to Melissa Caldwell, who is the

Page 35

mental health provider for ACH.
Q Okay. Anyone else?
A Not that I recall.
Q What did you talk with Melissa Caldwell about?
A Just the stress of having to give a deposition.
Q When did you talk with her?
A I talked with her shortly after the incident, and then I talked with her again last week.
Q How were you put in touch with Melissa Caldwell?
A I called her.
Q Was there a reason that you called her in particular?
MR. KNOTT: I think it's asked and answered.
Q Okay. I -- was there a reason you called Ms. --
MR. KNOTT: Oh, I'm sorry.
MR. WEIL: Yeah. Just --
MR. KNOTT: I'm sorry. I misunderstood the question, Steve. I'm sorry.
BY MR. WEIL:
Q Was there a reason you --
A Because I was -- sorry. I was stressed about the deposition.

Page 36

Q Okay. And how did you know to call Ms. Caldwell -- or Dr. Caldwell?
A She had -- during our orientation, we had been given the information, that if we ever had any stress or problems, that we could call Melissa and talk to her about them.
Q Do you work for ACH anymore?
A I do.
Q Okay. So when you gave me your employment, what you told me about your job, you said you worked for UnityPoint. In addition to that, you work for ACH as well?
A I do. I -- it's a part-time job.
Q Okay. And is that essentially the same job that you had at the time that -- the incident with Ms. Boyer?
A It is. Except I work for different jails now.
Q Okay. So -- and we'll get into the job momentarily. But, essentially, the job is serving as a nurse practitioner to a particular jail; is that right?
A Yeah. Yes.
Q And that job means being on call, and then paying occasional visits to the jail; is that right?
A That's correct.
Q Okay. Do you serve Monroe -- the Monroe

Page 37

County Jail anymore?
A I do not.
Q Okay. Turning back to the conversation with Ms. Caldwell, what did you talk about on the call, last week?
A She just discussed with me her expertise in giving depositions in the past, trying to reassure me that there was nothing to worry about. Nothing specifically about the case.
Q Okay. What did she tell you about her expertise in depositions? How did she describe that?
A She said she had been deposed before and that, you know, you just tell the truth, and try not to be worried about it.
Q Okay. You said that you also spoke with Ms. Caldwell shortly after the incident with Ms. Boyer; is that right?
A Yes. Yes.
Q Were you concerned about giving a deposition then, during that first conversation?
A I was concerned about the fact that one of my patients had passed away. I mean, that doesn't happen very often and it was stressful.
Q Okay. What did she tell you during that first conversation?

Page 38

A I don't recollect a lot about the specifics of the conversation. She just was reassuring.

Q What did you talk -- what do you recall talking about with Dr. Schamber?

A I talked about the case, what I had done, and what he -- his impression of the care that was given.

Q Was -- do you recall about when you had that conversation with him?

A It was probably shortly after we found out that Ms. Boyer had passed away.

Q Okay. And was it a call that was -- did you understand why the call occurred, in the sense of why Travis Schamber would be interested in talking with you?

A He was my supervising physician, and I called him to get his take on the care that I gave the patient.

Q Okay. Did you -- was it a call -- it was -- so it was a call on the phone, right?

A Yes.

Q Do you remember about how long it lasted?

A Not really.

Q Okay. One of the things I -- the instructions I didn't give you, but I should have, is that a deposition is not a memory test. I don't -- you know, we don't expect you have a perfect memory. As we've just reviewed, you remember fewer -- you have an

Page 39

independent recollection of fewer calls than the papers indicate that you got, right?

A Correct.

Q Okay. So it's not a memory test, but I am entitled to your best recollection, and also your best estimate. So can you estimate roughly, how long the call with Dr. Schamber may have gone?

MR. KNOTT: No. Counsel, I -- you shouldn't be instructing the witness, particularly if it's inaccurate. So she answers to the best of her ability. You're not entitled to estimates, if she doesn't have an independent basis for that. so I object to the form of the question. I'm going to let the witness answer to the best of her ability.

A I would say no more than five or ten minutes.

BY MR. WEIL:

Q Do you recall reviewing any documents with Dr. Schamber on that call?

A No.

Q Okay. Other than the call with Dr. Schamber, do you remember discussing with any and I -- well, to back up. It sounds like -- we just discussed your conversations with Melissa Caldwell; is that right?

A Yes.

Q And if I understand you correctly, you

Page 40

initiated those conversation -- that first conversation after Christine Boyer died because you were stressed about that situation. And during your orientation, you had been told that Melissa Caldwell would be a person at ACH you could talk to if you were stressed; is that right?

A Yes.

Q Okay. And that was the reason for the call, correct?

A Correct.

Q Okay. The call with Dr. Schamber, did you initiate that call or did he?

A I believe I did.

Q Okay. And I guess initiate is a little inaccurate. I mean, it may have been, he said, hey, let's set up a call, and then you call in. But do you remember how that call was set up?

A I don't. I had access to Dr. Schamber any time I needed it. So I may have called him and just wanted to discuss the case.

Q Okay. Besides speaking with Dr. Schamber and Melissa Caldwell, have you spoken with anybody else at ACH about Christine Boyer?

A No.

Q Okay. You did what -- I'll create another

Page 41

exception of that. You did you -- I think you testified earlier, you did speak with Amber Fennigkoh on the -- Monday the 23rd, right?

A Yes. Yeah.

Q Okay. So besides those three people, you don't recall speaking with anybody else about Christine Boyer at ACH?

A No.

Q Did you receive any -- did you speak with anybody else, be it the county, or the department of corrections, or anybody else about Christine Boyer?

A No.

Q Okay. Has -- do you recall anybody asking you questions, talking to you, e-mailing you in some sort of formal capacity, like an investigation, about Christine Boyer?

MR. KNOTT: Again, you're asking for her independent recollection. She has not looked at any records, as of this point in the deposition.

A No. I don't remember that.

BY MR. WEIL:

Q Okay. Or do -- setting aside your independent recollection, did any documents you reviewed in preparation for this deposition, indicate you'd spoken with anybody else about Christine Boyer?

Page 42

A Not that I can remember.
Q Okay. Do you know who Stan Hendrickson is?
A Yes.
Q Did you ever speak with him about Christine Boyer?
A Not that I -- not that I remember. No.
Q Okay. How about Jeffrey Spencer, do you know who that is?
A I do not.
Q Okay. When did you first learn about this lawsuit?
A It would have been some time last year.
Q Okay. And have you spoken with anybody about this lawsuit, besides your lawyers?
A My family.
Q Who did you talk to in your family?
A Just my husband and my daughter.
Q What did you say to your daughter about the lawsuit?
A Just that I was being deposed about a case from the jail.
Q Have you ever been sued before?
A No.
Q Where did you grow up, Ms. Pisney?
A Mostly in Wisconsin.

Page 43

Q Where'd you go to high school?
A Janesville, Wisconsin.
Q Did you go to college?
A Yes.
Q Where was that?
A Well, I went to Whitewater for a few years -- Whitewater, Wisconsin. I transferred to Luther College. Then I met my husband and after we were married, I finished my nursing degree at the University of South Carolina. And then I did my master's program at the University of Colorado at Colorado Springs.
Q How did you come to be in Colorado Springs?
A My husband was in the Army.
Q And your -- was -- so your degree at University of South Carolina was in what? I'm sorry.
A Nursing.
Q Okay. And then your degree from UCCS was -- what was that in?
A As a nurse practitioner, my master's of science in nursing.
Q Okay. Can you describe the difference between a nurse and a nurse practitioner?
A A nurse has a -- well, can have an associate's degree or a bachelor's degree, typically works in the hospital or an outpatient setting. Nurse practitioner has a hierarchy of education and is able to assess, diagnose, and prescribe medications for the treatment of illnesses of patients.

Page 44

Q When you say -- just -- when you say assess, diagnose, and prescribe, can you just tease out what you mean by assess?
A Evaluate, perform physical evaluations, physical exams, everything you need to be able to diagnose a patient.
Q Okay. How about diagnose? What does that refer to?
A Putting together the symptoms that a patient's having along with their physical exam to come up with a possible cause for their symptoms and -- yeah, symptoms
Q And then prescribe -- I think it's fairly self-explanatory. You have the privilege of prescribing medication; is that right?
A Correct.
Q And that's different than a nurse, correct?
A Correct.
Q Okay. Now, after receiving your nurse practitioner degree at UCCS, what did you do after that?
A Let's see. My first job as a nurse practitioner was at an independent occupational health clinic in Virginia.

Page 45

Q How long -- what years were you there?
A 2004. I was only there for approximately six months, and then I took a job with the Veteran's Administration in Richmond, Virginia in gastroenterology.
Q I'm sorry. It was gastro, what?
A Enterology.
Q Okay. And that was in Richmond, Virginia?
A Yes.
Q Okay. How long were you working at the VA in Richmond, Virginia?
A Approximately, five years.
Q So that would have been 2004 to roughly 2009, thereabouts?
A Or 2010, I believe. Yeah.
Q Okay. Then what did you do in 2010?
A My husband had retired from the Army and went to work for Fort McCoy in Tomah -- or Sparta, Wisconsin -- Fort McCoy, Wisconsin. And so I took a job with the VA in Tomah, Wisconsin to move and be able to live with him.
Q How long did you work at the VA in Tomah, Wisconsin?
A I was there for only a short time as well, about six months, before I got a job at the Mayo Clinic

Page 46

in Rochester, Minnesota.

Q How long did you work -- what was your job at the Mayo Clinic?

A I, again, worked in gastroenterology and hepatology with them.

Q How long did you have that job?

A Seven years.

Q So I'm doing math here, 2000 -- I guess, we're in 2010 to 2017; is that right?

A That's correct.

Q Okay. What did you do after that?

A I got a job at Gundersen in La Crosse, in gastroenterology and hepatology.

Q Okay. And how long did you work for Gundersen?

A I worked there from 2017 to 2021.

Q That -- I think you described your job with ACH is -- I guess, as something of a part-time job; is that right?

A Correct.

Q And so -- between 2017 and 2021, your full-time job was to work at Gundersen?

A Yes.

Q Okay. And what -- you said you worked in gastroenterology there?

Page 47

A Correct.

Q And that was in La Crosse?

A Yes.

Q What does that job entail?

A I saw patients that came to the outpatient clinic with any gastroenterology or hepatology complaints.

Q Okay. So you're working at an outpatient clinic there?

A Correct. I also worked some inpatient hospital patients.

Q Okay. And that -- there's a -- it does -- Gundersen is -- I'm not from this -- I'm not from Wisconsin. Is Gundersen a health network with multiple physical locations?

A Yes.

Q Okay. And some of those locations are outpatient, I guess; is that right?

A Yes.

Q Okay. And there is also a full hospital in La Crosse; is that right?

A That's correct.

Q What hours did you work at Gundersen, what was your schedule during this period?

A Monday through Friday, 8:00 to 5:00.

Page 48

Q Okay. So office hours?

A Yes.

Q Okay. And that was both at the outpatient and at the hospital?

A Yes.

Q Okay. And is it -- since 2001, you took the job, were you working at the Deere plant?

A 2021. Yes.

Q I'm sorry. 2021. Yes. Sorry. And that is your full-time job. as of today?

A Yes.

Q And then you have a part-time job with ACH, right?

A Correct.

Q How many jails do you -- have you serviced for ACH?

A In total three. But I did -- I did some coverage for other providers at times.

Q All right. One jail was Monroe County. When did you service Monroe County?

A I started there in 2019 to 2021.

Q You started working with ACH, I believe, somewhere around May 2019; is that right?

A Yes.

Q Okay. And then -- so you, the ja -- is it --

Page 49

what are -- I'm sorry. Just -- what other counties did you work for besides Monroe County?

A Well, while I was with Monroe County, it was -- my job was Monroe County. I did cover some other counties, when -- when other practitioners were gone. I don't remember exactly which ones. The ones I cover now are Clayton County in -- Clayton and Crawford County. One is in Wisconsin and one is in Iowa.

Q Okay. The Monroe County job was -- I'll just call it, a steady position, as in you were there over an extended period -- you had that job over an extended period; is that right?

A That's correct.

Q And the Clayton and Crawford Counties, those are -- you're filling in for folks?

A No. Those are my steady jobs now, too. They're smaller jails and require less time.

Q Okay. And so is that job similar to the job -- the manner in which the job is performed is similar to the job at Monroe County, in the sense that you're on call for most the time, and then there's some period where you physically go to the jail?

A That's correct.

Q Okay. Any other counties besides those two?

A Not as my -- my main job. No.

Page 50

Q Have you ever had more than one county at a time? Maybe you do now with these two, but...
A I do now. Yeah.
Q Okay. How many hours a week are you working for ACH?
A Currently, I am required to be at the jail one hour every other week, for both the counties that I'm serving. And then I'm on call for them, whenever they need me.
Q How about Monroe County, how long were you required to be in Monroe County Jail?
A Two hours a week.
Q Okay. Why did you stop working in Monroe County Jail?
A I moved to Iowa.
Q Okay. And in all these jails, whether working in Monroe County or these two, Clayton or Crawford Counties, the on-call requirement is -- doesn't require you to work any particular hours, it just requires you to be available, right?
A That's correct.
Q Would you -- can you estimate how many calls you get a week, in that on-call capacity?
MR. KNOTT: Object to form.
A With the two jails I'm serving now, it's --

Page 51

how many? Maybe five times a week.
Q Okay. How about --
A Monroe County was -- go on.
Q Go ahead.
A Monroe County was more often. I received at least one call a day from them.
MR. WEIL: Okay. How about we take a quick break? We can come back at 11:30?
MR. KNOTT: Sure.
THE WITNESS: Sure.
MR. WEIL: Okay, great.
MR. MCCAULEY: Sounds good. Thank you.
COURT REPORTER: We are off the record. The time is 11:25.
(OFF THE RECORD)
COURT REPORTER: We are back on the record for the deposition of Lisa Pisney being conducted by video conference. My name is Sidney Little. Today is March 3, 2022. The time is 11:32 a.m.
BY MR. WEIL:
Q Ms. Pisney, when we left we were talking about the positions you -- the different places you worked for ACH. I want to just go back over your employment history. I -- were you -- have you had any appointments to any boards or anything like that?

Page 52

A I haven't been employed by boards, but I've been a member of boards. I am -- was a member of the Wisconsin Nurses Association Board, the Association for Nurse Practitioners in Wisconsin, and the Wisconsin Board of Nursing.
Q Are those governmental appointments, any of them?
A The nurses -- the Wisconsin Board of Nursing is.
Q How did you come to be appointed in that position?
A I applied, and was accepted, and appointed by Governor Evers.
Q How long did your tenure last?
A I think it typically lasts four years or three years, but I had to leave early because I was moving to Iowa.
Q Was that a competitive process to become a member of that board?
A Yes.
Q Did you receive -- how -- was there a campaign to become part of it or was it just an application, or many applications, or do you know why you were selected?
A Just an application and I don't know why I was selected. Just at the discretion of the governor.

Page 53

Q Why did you want that job -- or that position, I should say?
A I -- I'm interested in advancing the rights of nurses, taking care of nurses, and advancing the rights of nurse practitioners in the State of Wisconsin, making sure that the patients in Wisconsin are well-taken care of.
Q What types of things did the board do to make sure that the patients in Wisconsin were well-taken care of?
A We review complaints against nurses, and adjudicate those, and place any restrictions on nursing licenses, take away nursing licenses, restrict them for different things.
Q Okay. What was your involvement? You described the board as doing that. What was your involvement in adjudicating and receiving complaints for the Wisconsin Board of Nursing?
A I was one of the member of the board. We talked about each of the cases and agreed together, based on history, how we placed restrictions on nurses. It was -- it was a board decision for all of the restrictions we'd place or the --
Q Was -- I don't know if you're done with the answer. You paused, Ms. Pisney. I don't know if you're

Page 54

done or not?
A Yeah. I'm trying to think of the word to use, but discipline -- discipline.
Q Okay. Where did you conduct? Was that done in hearings, or was it all on paper, or how would that work?
A We met monthly and discussed the cases. We each took three months, where we were more in depth in hearing the cases. We met with the lawyers and for the -- for Wisconsin, for Board of Nursing and discussed the cases. We looked over the documentation from each case and made decisions. There was usually another nurse pract -- or nurse that was on those calls. And we decided together on whether we should proceed with any discipline, whether no discipline was necessary. And then we brought that back to the board as a whole.
Q Was this discipline oversight, was that nurses and nurse practitioners?
A Yes.
Q Okay. Do you ever recall receiving disciplinary complaints about nurses who'd ignored chest pain?
A I don't recall any.
Q Okay. Do you recall receiving any complaints about nurses who ignored signs of a heart attack?

Page 55

A I don't have any specific recollection.
Q Do you remember any cases, complaints or otherwise, with the Wisconsin Board of Nursing that involved heart attacks?
A I do not specifically. No.
Q Okay. Do you have a general recollection that there were some?
A No.
Q Okay. Did you -- once you were on the board, were you involved in reviewing applications by additional nurses to join the board?
A No.
Q Okay. It's an impressive accomplishment, at least from this outsider's view, to be on this board. What were the other nurses like on the board? What were their accomplishments?
A The chair of the board is a certified registered nurse anesthetist, who is a professor of nurse anesthetizing or whatever. There's another professor on the board at the school of nursing, I believe, in perhaps Madison. I'm unsure. There are several members that are RN representatives. There's at least one general member of the board that is not a nurse. There's an LPN representative.
Q Once you're appointed to the board, were you

Page 56

asked to speak about nursing? Like do you do any public speaking or anything of that sort?
A Not in relation to the board of nursing, but I have given talks in relation to my expertise in gastroenterology and hepatology.
Q Okay. And that's your specialty within your LPN field? Is that --
A I'm a nurse practitioner.
Q I'm sorry. I apologize. Your nurse practitioner field?
A That's what I've done most of my career in. Yes.
Q Where have you given talks or -- in what forums?
A Conferences, usually -- nursing conferences. Nurse practitioner conferences.
Q Okay. Anywhere else?
A No. Not that I can remember.
Q Very quickly. Just returning to the disciplinary issues that you were involved in on the Wisconsin Board of Nursing. In terms of discipline for -- disciplinary issues involving nurse practitioners, do you ever recall discipline for failure to diagnose?
A No.
Q Okay. Going back to your schedule with ACH

Page 57

and I'll just direct you to your time in Monroe County. I understand that you're now working somewhere else. As we discussed, you're available -- when you're working from Monroe County or at Monroe County, you're available during the week to receive calls, and then you go in one day a week to the jail; is that right?
A Yes.
Q And that was -- I believe you said earlier, that that day was typically Monday; is that right?
A That's correct.
Q Okay. And why are you going to the jail physically, one day a week? What's the purpose of those visits?
A I had signed off on paperwork from the week, and I also saw patients that we were having any problems with or that wanted to see a provider.
Q Okay. So when you're saying you sign off on paperwork, what does that refer -- what paperwork are you signing off on?
A The MARs for patients, the -- typically if a patient wants to be seen by the nurse, they'll fill out a form. And then the nurse sometimes will call me with those forms and ask my opinion, ask for any med changes, anything that needs a provider. And then I would sign off on that. So any orders or anything that I'd given

Page 58

during the week, sign off on those.
Q Okay. And in terms of seeing people who wanted to see a nurse practitioner, how would that work? Do you go to a -- sort of, logistically?
A So there's a nursing office in the jail. Amber typically would set patients up for me to see, ones that had, you know, complications with any wounds, any injuries, any questions, complaints, wanting to talk about their medications. They would be called down to be seen. Sometimes a CO would come with them, sometimes not. They would come into the nurse's office. Amber would do their vital signs and take the chief complaints. Then I would talk to them about their complaints, do any assessment that was necessary, give my opinion, and any plan for their care.
Q Okay. I'm assuming as these folks are coming down, you're reviewing whatever medical history they have?
A Whatever we have. Yes.
Q Right. And as I understand it from discovery in this case, every detainee at the jail has a medical file, be it just a few documents or many; is that right? As best you know?
A That's correct.
Q Okay. And that includes an intake sheet where

Page 59

that's filled out when they're they come in, right?
A I don't -- I don't see those intake sheets, normally.
Q Are those in the medical file?
A I'm not sure they are.
Q Okay. Have you ever seen one in your work at the jail?
A I've seen one for this case, but I'm not sure I've ever seen them before. I think that's all part of the jail paperwork, and I don't typically see the jail side of the -- of why they're there, their charges, all that kind of stuff.
Q When you're looking at a medical file of a detainee, just -- literally, physically, it's a paper file, like with an envelope -- like a manila envelope or that kind of thing?
MR. MCCAULEY: Object to form.
A We have files for the patients. Yeah. Typic -- it would include like any request for a nurse visit in it. Not sure if it includes their intake evaluation or not. It might. I just can't remember. If we'd have any outside records, it would include that. There is a form that they fill out when they come in, that they answer questions about medical history, and that -- that's typically filled out by the -- the inmate

Page 60

themselves.
Q Okay. And this is a -- just physically, it's like a folder with loose paper in it, or how does that work?
A Yes. Yeah. During my time at Monroe County, they did get electronic paperwork, but that was later on during my time there.
Q And when you say electronic paperwork, what do you mean?
A Or electronic medical records. So instead of physically signing off on the papers, I would still do some of that, but I would sign off on things that were in an electronic database.
Q Okay. I have two versions of electronic files in my mind. One is just a bunch of paper that's scanned and, you know, it's something you maybe hand wrote on and that just gets scanned and that's the electronic, and maybe there's a bunch of like handwritten stuff or typed out -- just scanned paper in a file. Another version would be like, you know, computer entry forms, like access database, something you'd be familiar with from like a modern hospital. Is that a distinction that makes sense to you?
A Yes.
Q Which version are you talking about, in terms

Page 61

of at Monroe County?
A It would've been -- it would've been after this case that we got the electronic medical record and that would've been, because I put my notes in into it electronically -- the nurses' notes were entered electronically. It wasn't scanned documents.
Q Okay. So this is -- you're doing computer entry into -- are they sort of electronic forms like -- or is it a -- but what is it?
A Yes. It's an electronic form that looks very similar to the paperwork I would fill out previously.
Q Okay. And roughly, when did that switch occur to the electronic forms?
MR. MCCAULEY: Object to form. Foundation.
A That was just shortly before I left. It wasn't -- just a few months before I left.
Q Okay. And so previously you'd been writing stuff down on paper, and then it switched over to doing entry on a computer?
A Yes.
Q Okay. So turning away from your time when you were actually physically at the jail, in terms of your being on call, can you tell me how the call -- the on-call call works, when you're called off-site, What the procedure is?

Page 62

A I would just receive a call from either the nurse or the correctional officer with questions about a patient or -- or whatever they had an issue with.

Q Is your availability something like -- I'm picturing doctors with a pager or something like that. Is there a procedure that you have to keep a phone on you at all times? Or are there times where you were definitely available, and then other times where it might be somebody else who's on call?

A Unless we asked for time off, we were always on call. There was always a backup provider though, if they couldn't contact us.

Q Okay. And so you then could just be doing anything, you're just going about your life, and you would take a call?

A That's true.

Q Okay. Did you have a place at home or anything of the like -- an office where you'd typically sit down and take these calls when they came in?

A No.

Q Okay. Did you have any medical reference literature that you'd use, when you took calls from the jail?

A Yeah. I had Epocrates that I use a lot for making sure I'm giving the correct dose of medication

Page 63

for the -- for the disease processes.

Q I'm sorry. I didn't understand that word. You just said Epocrates?

A Epocrates. Yeah. It's an app on my phone.

Q Okay.

A It's a medical app.

Q How do you spell that?

A E-P-O-C-R-A-T-E-S.

Q Okay. Besides the Epocrates app, did you have any other sources of literature available when you took a call?

A I mean, I have my own library of -- of medical books for assistance. Typically, they weren't right at my hand when someone would call, and I don't remember specifically picking up a book, and looking at it for any particular questions. Typically, they were something that I just knew from my education and experience.

Q I believe as a nurse practitioner it's referred to as a mid-level practitioner; is that right?

A A what?

Q Mid-level practitioner?

A That's what some people call us. Yes.

Q Meaning, as I understand it, you know, the contract between -- well, your employment agreement has

Page 64

been produced and several other things, without getting into it. My understanding is that you are a practitioner, and then as a nurse practitioner, you practice under a doctor; is that right?

A In collaboration with a physician in Wisconsin, we do. It just depends on the state you work in. In Iowa, they have independent practice.

Q Okay. And how is it in Wisconsin?

A Currently, we work in collaboration with the physician.

Q Okay. And the collaboration physician I saw in the documents was Dr. Schamber when you were at ACH, at Monroe County; is that right?

A It was during part of the time I was there. Dr. Schamber left ACH at some time, and I had another collaborating physician after him.

Q When Ms. Boyer was at the jail, was your collaborating physician Dr. Schamber?

A Yes.

Q In terms of your working relationship -- or working interactions with a collaborating physician, what interaction do you have on a day to day with a collaborating physician, in this role at ACH?

A I -- I didn't speak to him every day. I spoke to him if I had any questions. There was regular

Page 65

evaluation of my notes to make sure that I was following, you know, appropriate medical care of the patients.

Q Okay. And when you're talking about notes, where would you be recording those notes?

A At the time of the Boyer case, they were handwritten notes. When I would see a patient.

Q Sure. It was a poorly phrased question. Would you be recording notes only when you were visiting the jail, or would you be recording them as well when you took calls off-site?

A No. Only when I would visit the jail and see a patient in person.

Q Okay. And so the collaborating physician is reviewing your notes that you may enter, when you're in the jail. And then I believe the other thing you said, is that you might contact the collaborating physician for a medical question; is that right?

A Yes. If I had questions or concerns, I could call them.

Q So if that would -- in my mind that sounds like you get a question from the jail, you say, well, I'm not quite sure what the right answer is medically. I'll call the collaborating physician and talk about it with them; is that right?

Page 66

A It could be. Or I could -- yeah. If I had a question about how to treat a certain diagnosis, I would sometimes call him and ask his opinion.

Q Okay. How often do you recall having conversations like that with the collaborating physician?

A I didn't call often. I think I maybe call Dr. Schamber -- especially when I first started, I called him a little more often if I was unsure. But then as time went on, I had to call him less. He was very familiar with treating inpatients -- or inmates. So maybe once or twice a month, I'd give him a call.

Q Do you recall calling anybody, a collaborating physician or anybody else in Ms. Boyer's case?

MR. MCCAULEY: It's vague and overly broad. But you can answer.

A I didn't call them during the time I was treating her. No.

Q Okay. We talked a bit ago about the difference between a nurse practitioner and a nurse. And you talked about assessment, diagnosis, and prescription. Can you describe how the diagnosis process works?

A You take into consideration the symptoms that the patient is having, their physical exam. There are

Page 67

several differential diagnoses for symptoms and physical exam findings that you take into consideration.

Q You said differential diagnosis?

A Correct.

Q Is the purpose of differential diagnosis to look for a cause of patient's signs or symptoms?

A Yes. Yeah. It gives you a number of different options that those signs or symptoms could be indicative of.

Q Okay. What do you mean by it gives you a bunch of different options?

A You know, certain symptoms could be indicating many different diagnoses.

Q Okay. And when a symptom indicates many different diagnoses -- why don't we just -- let me back up for a minute. Is the goal of differential diagnosis to identify the cause of a patient's signs or symptoms without missing something that could cause a danger to the patient?

MR. MCCAULEY: Object to form.

A There are certain things -- oh, I didn't hear. There are certain things that are red flags that you would want to be aware of.

Q What does a red flag mean?

A Something that you don't want to miss.

Page 68

Q And what is something you don't want to miss?

A Something that could lead to a serious medical condition.

Q Okay. And so just go back -- you were saying, there are certain red flags that you are seeking to identify in a differential diagnosis; is that right?

A Sure. So for low back pain, a red flag might be a person's age, their history of cancer, those sort of things.

Q Is differential diagnosis, is there sort of a multi-step process that you go through together?

A No. Differential diagnosis -- differential diagnosis are, okay. I have this symptom. It can be caused by this, this, this, this, or this. So making a diagnosis is an art. It is some -- to me, it is like solving a mystery.

Q How so?

A You have to look for clues, and you have to fit those clues into the different diagnoses, rule out certain diagnoses because of the clues, and rule some in. So, much like solving a mystery.

Q When you -- described -- working forward, the differential diagnosis, I think you said begins when someone comes and presents to you with symptoms; is that right?

Page 69

A Yes.

Q And so the first step in a differential diagnosis is to gather information about those symptoms; is that right?

A That's correct.

Q So that would be their subjective symptoms, correct? What they're telling you?

A Yes. And objective. You use subjective and objective data.

Q Right. So subjective is, if I understand it correctly, that's what someone is telling you about what they're experiencing; is that right?

A That's true.

Q Okay. And then objective is, what you observe about the person?

A Yes.

Q Okay.

A Yes.

Q And when someone presents you with symptoms, part of what you're gathering is also their medical history, right?

A Yes. That's part of the subjective. Yes.

Q And it's important to gather the medical history for a person, in order to understand what might be causing their symptoms; is that right?

Page 70

A That's --
MR. KNOTT: Vague and overly broad. Go ahead. I think she answered.
A That's true.
Q Okay. Once you've gathered the symptoms, the objectives, observations, the subjective observations, and the history, what's the next step in the differential diagnosis process?
A You know, using your knowledge to put those subjective and objective data together to make a diagnosis.
Q Are you trying to identify potential causes for symptoms, given the information about their history, what -- the objective and subjective observations you're making?
A You're trying to come up with a diagnosis for the -- the bunch of symptoms and objective data that you have. And then based on that diagnosis, a plan for their care.
Q So let me see if I understand how this would work. I give an example of say someone who comes in with a abdominal pain, right? And you gather the information from this case, they're saying, I have severe abdominal pain. And once you've gathered that information -- this is a very simple case. I'm not

Page 71

providing a bunch of history. You would say, okay -- you said it's like solving a mystery. The next thing -- the next step in the differential diagnosis would be to say, well, I'm going to make a list in my mind, on paper, wherever -- I'm going to make a list of all the potential causes for that symptom of abdominal pain, right?
A That's correct.
Q And that's an important step in the differential diagnosis process, because you don't want to miss a potential cause, right?
MR. KNOTT: It's vague and overly broad.
A Yeah. And any symptom can have multiple causes. So the differential diagnosis is that list of multiple causes that it could be.
Q Right. So we'll stick with my example of abdominal pain. You know, one of the causes could just be gas, right?
A True.
Q Another could be something more serious, like a tumor, right?
A It's possible.
Q Okay. And then you could have something else, like appendicitis that could be another potential cause of abdominal pain, correct?

Page 72

A That's true.
Q Once you've gathered -- and you're trying to make an exhaustive list of potential symptoms; is that right? Or a potential causes for symptoms?
A Yeah. That's what a differential diagnosis is. Correct.
Q Okay. Once you've identified potential causes for the symptoms, the next step in the differential diagnosis, if I understand it, is that you'd want to prioritize symptoms within that. So you'd want to, you know, in the list, in your mind on paper, wherever, you'd want to say, well, tumor is serious, but maybe not emergent, right? So that would go a slightly higher priority on your list, correct?
A So you try to whittle down or narrow down the differential diagnosis based on the symptoms that you're given and the history.
Q Right. And if a symptom has a potentially very benign cause, that goes on the list, right? Something like gas, in our abdominal pain example, correct?
A Yes.
Q And then if a symptom has a potential very serious cause like appendicitis or a tumor, that would go on the list as well, right?

Page 73

MR. KNOTT: Object to form of the question. It's vague. Overly broad.
A Yes.
Q Okay. The next step, once you've made that list, is that you want to rule out or treat any potential cause that would pose a danger to the patient before it can hurt them; is that right?
MR. KNOTT: Vague. Overly broad.
A I mean, you want to rule out the serious causes first --
Q So --
A Benign or --
Q Go ahead. I'm sorry. Go ahead. I didn't mean to interrupt you.
A The benign can take longer and not be as serious, I guess.
Q Okay. And so in my abdominal pain example, and we'll just have, you know, in our example, we have three potential causes that we're just going to say. I suspect you're aware of many more given your specialty, but we'll just say there's three potential causes. One is gas, one is a tumor, and one is appendicitis. Are you with me in our hypothetical here?
A Yes.
Q Okay. And so a gas is a benign cause for

Page 74

abdominal pain, or at least one that doesn't need to be ruled out or treated immediately, right?
A True.
Q A tumor is a serious cause. But one that wouldn't be necessarily emergent, where it would have to be ruled out, you know, in a very short time; is that right?
A Depends on the tumor, I guess.
Q Sure. I guess, you know -- of course, I guess we're speaking in a matter of days or hours versus a matter of weeks, right?
A Uh-huh.
Q Okay. So some -- fair enough. But then something like appendicitis would be a very serious cause, that would have to be ruled out very quickly; is that right?
MR. KNOTT: Form. Vague. Overly broad.
MR. MCCAULEY: Joined.
A Appendicitis is serious and you want to make sure you don't miss it. That's true.
Q And the reason you want to -- and the way you don't miss it is by ruling it out or treating it, correct?
MR. KNOTT: Object. Vague. Overly broad.
A Correct.

Page 75

Q Okay. And the reason you want -- it's important, whatever your list of potential causes you come up with, it's important to rule out or treat any potential cause that can harm the patient, before it has an opportunity to harm the patient, right?
MR. KNOTT: Vague. Overly broad.
A I mean, in your first -- of course you don't want to miss anything that could harm the patient.
Q Okay. And to make sure you don't miss it, you want to rule it out; is that right?
MR. KNOTT: Object to vague. Overly broad.
MR. MCCAULEY: Joined.
A So you -- I mean, you can't always rule it out. There's -- I mean, many times there can be more than one diagnosis that fits.
Q Okay. Is that -- you mean, there might be, for -- again, in our abdominal pain case, there might be multiple causes for the same condition?
A For the same symptoms. You know, you have to -- and you have multiple ways of ruling things out, like, you know, imaging, and lab work, and different things that are not always immediately available.
Q Okay. And so if something isn't immediately available to rule out a dangerous cause, it's the job of the nurse practitioner to get the patient to a place

Page 76

where the equipment or procedures are available to rule out that dangerous cause; is that right?
MR. KNOTT: Object. Vague and overly broad.
A That would depend on how -- how likely you feel that might be the issue.
Q Is it your -- so if you feel that a potentially dangerous cause is unlikely, there's no need to rule it out?
MR. KNOTT: Object. Misstates the testimony. Vague and overly broad.
A If it's unlikely, then you may not have to rule it out. There are certain rules for when you do or don't need an x-ray. If you suspect there could be a fracture, there are certain indications that the x-ray is not necessarily needed. There are many things that you take into consideration, including the history, the age of the patient, their family history, social history. I mean, there's a lot of things that go into making that diagnosis.
Q You just mentioned x-rays for fractures; is that right?
A That's true.
Q Are you -- what were you referring to you there -- what injury or suspected condition were you referring to?

Page 77

A Just if someone comes in with ankle pain and, you know, there are -- there's these conditions called Ottawa rules. That if they don't have a pain in this certain place or this certain finding, then the likelihood of a fracture is low and you don't need to get an x-ray.
Q Okay. Would do the Ottawa rules also cover -- what do they cover?
A Usually fractures.
Q Okay. Anything else? Any other conditions?
A No. Not as far as I know.
Q A fracture would be different than something like appendicitis, in the sense of the harm it could cause to you; is that right?
A It can still leave lasting damage. I mean, appendicitis undiagnosed could cause serious a medical problem, too. But an undiagnosed fracture can lead to serious medical complications as well.
Q Okay. The important -- can an undiagnosed fracture -- it sounded like an undiagnosed fracture of an ankle was an example you gave, right?
A Yes.
Q Is that something that can kill you?
A In certain circumstances, I suppose it could. Not usually.

Page 78

Q Those would be pretty -- yeah. Not usually, right? Can an undiagnosed heart attack kill you?
MR. MCCAULEY: Object to form.
MR. KNOTT: Join.
A That -- that depends, too.
Q Okay. Is it possible for an undiagnosed heart attack to kill you?
MR. MCCAULEY: Objection.
MR. KNOTT: Form.
A It's always possible for a heart attack to cause death. Yes.
Q Because it's possible for -- and an undiagnosed heart attack can kill you within a matter of minutes or a matter of hours, correct?
MR. MCCAULEY: Objection.
MR. KNOTT: Yeah. It's vague.
A There are heart attacks that can kill immediately, and then there are heart attacks that lead to some damage and don't necessarily bring death.
Q Okay. But many heart attacks do bring death; is that right?
MR. MCCAULEY: Same objection.
A I don't know if I would say many.
Q I'm sorry.
A I said, I don't know if I would say many. I

Page 79

would say some.
Q Would you agree that a heart attack is an extremely dangerous event for a person suffering it?
MR. MCCAULEY: Same objection.
A A heart attack is an emergency. Yes.
Q Okay. And why is it an emergency?
A They need to be evaluated emergently.
Q Why is that?
A To prevent them from further harm.
Q Does that harm include death?
A Yeah. Any medical issue can include death.
Q Is death from a heart attack more or less likely than death from a broken ankle?
MR. KNOTT: I object to the form of the question.
A It's -- I'm sure it would be more likely to be death from a heart attack than a broken ankle.
Q Okay. And death from a heart attack can occur in a short period of time, meaning minutes or hours; is that correct?
MR. KNOTT: Object to the form. Asked and answered. Vague. Overly broad.
A The faster it could be diagnosed, the better.
Q That wasn't my question. My question was, death from a heart attack can occur within minutes or

Page 80

hours; is that correct?
MR. MCCAULEY: Object to form.
MR. KNOTT: Vague, overly broad. Minutes or hours from what? But -- incomplete hypothetical.
A Yeah. I'm unsure. I mean, it doesn't necessarily mean you're going to die, if you have a heart attack.
Q Okay. Death from a heart attack can occur within minutes or hours of the manifestation of symptoms; is that correct?
MR. MCCAULEY: Same objection.
MR. KNOTT: Same objections.
A It's possible, but not always.
MR. MCCAULEY: Ms. Pisney, did you answer?
A Yes.
Q What was your answer? I didn't get it.
A Possible, but not always.
Q Okay. So sometimes it can kill within minutes or hours and sometimes it won't; is that right?
A That's true.
MR. KNOTT: Object to the form of the question. It's vague. And it's incomplete hypothetical, therefore lacked foundation. You can answer.
A Yes. You can -- it can happen quickly. It

Page 81

can happen slowly. It cannot happen at all.
BY MR. WEIL:
Q Would you agree that without knowing in advance whether a heart attack will ultimately lead to death, it's a possibility that you have to address when you're in -- as part of the differential diagnosis process?
MR. KNOTT: Object. It's vague. Overly broad. And incomplete hypothetical, therefore lacks foundation.
BY MR. WEIL:
Q Let me strike. Then I'll ask you a new question, Ms. Pisney. If it's possible for a heart attack to kill you within minutes or hours of the manifestation of symptoms, you have to rule it out or treat it, before it has the opportunity to kill the patient; is that right?
MR. MCCAULEY: Object to form.
A It would be important to make a diagnosis of a heart-related condition from symptoms. But -- I mean, I -- people complaining of chest pain, complain of chest pain for many different reasons.
Q Is one -- okay. Is one of those reasons, that they're actually experiencing chest pain?
A Any pain of the chest is chest pain. It

Page 82

doesn't necessarily mean it's from the heart. It can be anxiety, it can be reflux, it can be any number of things.

Q It can be any number of things; is that right?

A That's right.

Q And one of those things can be the onset of a heart attack; is that right?

MR. MCCAULEY: Object to form.

MR. KNOTT: Join.

A That is one of the symptoms. Yes.

Q That's one of the causes of chest pain; is that right?

MR. MCCAULEY: Object to form.

A Is -- is -- cardiac related is a -- is a cause of chest pain. Yes.

Q Okay. And one of the cardiac related causes of chest pain is the onset of a heart attack; is that right?

MR. MCCAULEY: Same objection.

A It's possible.

Q It's possible?

A Yes.

Q And in that last step of the differential diagnosis, it's vital to rule out or treat a cause of a symptom you're observing, that can possibly kill

Page 83

someone; Is that right?

MR. KNOTT: Object to the form of the question.

MR. MCCAULEY: Join.

MR. KNOTT: It's vague. Overly broad. Incomplete hypothetical.

A You would want to rule out the most serious diagnosis first.

BY MR. WEIL:

Q And you want to rule out the most serious potential diagnosis first, in a time frame before it's able to kill the patient; is that right?

A Yes. You don't want to kill the patient.

Q Just bear with me, Ms. Pisney. I'm going to show you a document.

MR. WEIL: I believe we are on Exhibit 28. And this is -- so we'll mark this as Exhibit 28, and for the court reporter, Sydney, what we're doing is, we are just continuing with the exhibits from the prior depositions and using those as static numbers, so...

(EXHIBIT 28 MARKED FOR IDENTIFICATION)

COURT REPOTER: Okay. Thank you.

BY MR. WEIL:

Q This is an infographic provided by the

Page 84

American Heart Association. Are you able to read this document on the screen, Ms. Pisney?

A I can't read what it says under each of the numbers.

Q Okay. I'll zoom in a little. We can see the -- this is the entire document. It's one page. And it says, "Common heart attack warning signs," do you see that?

A I do.

Q Okay. I will zoom in a little and hopefully that'll allow us to discuss this. One of the -- the first sign that's indicated is, "Pain or discomfort in the chest," do you see that?

A I do.

Q Another sign is, "Nausea, or vomiting, or lightheadedness," do you see that?

A Yes.

Q A third is, "Jaw, neck, or back pain," do you see that?

A Yes.

Q A fourth sign is, "Discomfort and pain in the arm or the shoulder," do you see that?

A Yes.

Q And this number four in the diagram is on the left side of this person's body, in Exhibit 28, right?

Page 85

A Correct.

Q When someone's exhibiting symptoms of a heart attack, is it the case that -- especially indicative is pain on the left side of the chest area or the shoulder?

A Yes. That would be more common, since the heart is on the left.

Q Okay. And then the fifth sign here is, "Shortness of breath"; is that right?

A Yes.

Q Would you agree that heart attack -- that those signs and symptoms that we just discussed can come and go, when someone is having a heart attack?

MR. KNOTT: Object to vague and overly broad.

A They -- they can.

Q Okay. And so the fact that the symptoms have dissipated momentarily is not a sign that someone is not having a heart attack; is that right?

MR. MCCAULEY: Object to form.

Q Let me rephrase that. The fact that someone's -- those, the signs that we were just reviewing, one of more of them may have dissipated momentarily, that does not rule out the possibility that someone is still having a heart attack; is that right?

A People can have a heart attack with no signs or symptoms as well.

Page 86

Q Does one of the things that -- these signs, however, are clues that someone is more likely to be having a heart attack, right?

MR. MCCAULEY: Object to form.

A Clues that it's possible.

Q And if someone's exhibiting one or more of these signs and symptoms, it's important to rule out the possibility that they're having a heart attack; is that correct?

MR. MCCAULEY: Same objection.

MR. KNOTT: Object. It's vague and overly broad. Incomplete hypothetical.

A I wouldn't say that one symptom would be indicative of a heart attack. There's many -- I mean, if someone came to me with nausea and vomiting, that's not the first thing that I would think of.

BY MR. WEIL:

Q Okay. If someone's having chest pain, pain in the shoulder, shortness of breath, nausea and vomiting, would those be symptoms that someone might be experiencing a heart attack?

MR. MCCAULEY: Object. Incomplete hypothetical. Vague.

MR. KNOTT: Join.

A It's possible.

Page 87

BY MR. WEIL:

Q If given that it's possible, is a heart attack something that it would be important to rule out if you're providing medical care to that person?

MR. MCCAULEY: Same objection.

MR. KNOTT: Same objection. It's asked and answered. Vague. Overly broad. And incomplete hypothetical.

A You know, every -- every patient is different. Every patient has a different history. Every symptom is expressed differently. So it's all very individual.

BY MR. WEIL:

Q If different individuals were experiencing the same symptoms that I just described to you, is there one for whom you would not try to rule out heart attack?

A There are certain individuals where a heart attack would be extremely unlikely. A 20-year-old is unlikely to be having a heart attack.

Q Okay. And so if a 20-year-old were experiencing pain or discomfort in the chest, nausea or vomiting, discomfort in the shoulder or arm, in the left shoulder, and shortness of breath, you would not attempt to rule out a heart attack at that point?

MR. KNOTT: Vague. Overly broad. Incomplete hypothetical.

Page 88

A I'd be asking a lot more questions about any drugs that they might have done recently, any cardiac history, any family history.

Q And those questions would be designed to rule out the possibility of heart attack, right?

A Yes.

Q Okay. And it would be important to rule out the possibility of a heart attack in someone experiencing the conditions we just discussed, because heart attacks can kill within hours or minutes; is that right?

MR. KNOTT: Object to the form of the question. It's vague. Overly broad. It's also been asked and answered three times.

A I did say that that could be one of the symptoms. But -- or -- yeah. But I've answered it.

MR. KNOTT: Stop. Stop. Can you ask the question again? She clearly didn't have the question in mind.

MR. WEIL: If you could read it back, Sydney.

COURT REPORTER: Just one moment, please.

AUTOMATED VOICE RECORDING: Recording in progress.

COURT REPORTER: Sorry. One moment.

(REPORTER PLAYS BACK REQUESTED

Page 89

TESTIMONY)

A So as I said before, it's possible that it can happen quickly, happen never, happen slowly. There are many people that have heart attacks that are undiagnosed at the time and they are diagnosed afterwards.

Q I don't believe you answered my question, Ms. Pisney, because it had to do with whether it was important to rule it out because it's possible for a heart attack to kill within hours or minutes?

MR. KNOTT: Object to form. Compound question. Facts not in evidence.

A It's important to rule out a cardiac cause of chest pain.

Q Okay. And it would be even more important to rule out -- chest pain is number one on this list, right? The first heart -- that little blue heart, right?

A Yes.

Q So even chest pain on its own, it would be important to rule out a heart attack for chest pain on its own, right?

MR. KNOTT: Objection. Mischaracterizes.

A Not every chest pain is a heart attack.

Q Right. But it's important to rule out that it's not a heart attack in the differential diagnosis;

Page 90

is that right?
MR. MCCAULEY: Asked and answered.
MR. KNOTT: Same objections.
Q Ms. Pisney, there's a question pending. Do you need me to ask it again?
A Yes.
Q Okay. If a person exhibited just that first, the little number one blue heart, pain or discomfort in the chest, you would want to rule out -- it would be important to rule out a heart attack, even if they just had that one symptom; is that right?
MR. KNOTT: Object. It's vague. Overly broad. And incomplete hypothetical.
A It would depend on the person.
Q Okay. What kind of a person would you not feel the need to rule out heart attack, if they presented with pain or discomfort in the chest?
MR. KNOTT: The same objections.
MR. MCCAULEY: Vague.
A I believe I answered that previously, when we had the discussion about the 20-year-old.
Q Okay. So it would be a 20-year-old where you wouldn't feel the need to rule out heart attack as a cause of chest pain?
MR. KNOTT: Object. Vague. Overly broad.

Page 91

A Every -- every patient that presents with chest pain is not someone that is having a heart attack, so many different things go into that diagnosis. And, you know, heart attack is one cause of chest pain.
Q Right. And in the list that you're making -- in your differential diagnosis list, it's the most serious and the most emergent; is that right?
MR. MCCAULEY: Object to form.
MR. KNOTT: Object -- that -- completely void of any context. Vague. Overly broad. Incomplete hypothetical.
A Not necessarily. There are other causes.
BY MR. WEIL:
Q Other causes even more deadly and severe than heart attack?
MR. KNOTT: Same objections.
MR. MCCAULEY: Object.
A It's very -- I mean, there are so many causes of chest pain. I mean, there's aortic aneurysm is one I can think of that would be maybe more emergent.
Q Okay. Is that something you would want to try to rule out as well?
MR. KNOTT: Same objections.
A Yes. That would be a serious thing that you would want to rule out.

Page 92

Q Okay. If you ruled out aortic aneurysm, you'd still want to rule out a potential second cause like chest pain; is that right?
MR. KNOTT: Object. Vague. Overly broad. And incomplete hypothetical. Asked and answered.
A I believe I answered before that chest pain is a serious complaint that needs to be investigated.
Q It needs to be ruled out, correct? Or treated?
MR. KNOTT: This is going on -- I'm going to start -- I'm going to have a real problem with the asked and answered nature of this. You've been at differential diagnosis for an hour and five minutes, and so, object to form --
MR. WEIL: Okay. Doug, you're making -- I just want to note for the record, you're making really frivolous asked and answered objections. The question that you just objected to as asked and answered was, if you've ruled out aortic aneurysm, you'd still want to rule out chest pain? It's the first time aortic aneurysm has been mentioned in this deposition. So it's just not possible that it's been asked and answered. I'm just trying to get clear answers from this witness on this topic and move forward. That's all I'm trying to do

Page 93

here. Okay?
MR. KNOTT: Yeah. Don't interrupt me. And the problem is, you say you're looking for clear answers. You get the clear answer 15 or 20 times, and you keep doing it, and it becomes harassment, and abuse of the process. And you think you're the only one who can talk and speak during these depositions, and you're wrong. I have to protect my witness from harassment. And, Steve, I think you're a nice guy. But I think you try to beat these witnesses with repeated questioning, until you get exactly the words you want, and that's not what this process is about. So, you know, I'm going to protect her. You ask the questions and that's how we'll go.
MR. WEIL: Okay.
A So heart attack would be one of the things that you want to rule out.
BY MR. WEIL:
Q Okay. Would you agree with me, Ms. Pisney, that someone having high blood pressure is a risk factor for having a heart attack?
A Not necessarily.
Q What's that?
A Not necessarily.

Page 94

Q Is it possible?
MR. MCCAULEY: Object to form.
A There are many people that have high blood pressure that have never had a heart attack. It's not a risk factor for a heart attack.
MR. WEIL: I'm showing you now, what we'll mark as Exhibit 29. This is a publication by the US Department of Health and Human Services. It's four pages long. I'll scroll through it with you.
BY MR. WEIL:
Q Can you see it on the screen, Ms. Pisney?
(EXHIBIT 29 MARKED FOR IDENTIFICATION)
A I can see it, but I can't read it.
Q That's fine. We'll get to reading it. Do you see here on the first page of Exhibit 29, it says, "Major risk factors for a heart attack you can control, include smoking, overweight and obesity, high blood pressure, cholesterol, diabetes, an unhealthy diet, and lack of physical activity," do you see that?
A I do.
Q Do you agree?
A I think that that's --
Q Go ahead.
A I think that's as -- overall. I mean, you have a risk factor if you smoke, if you're overweight,

Page 95

if you have high cholesterol, and high blood pressure, and diabetes, and an unhealthy diet, and don't exercise. I mean, that's just unhealthy.
Q Are you -- so maybe we should clarify something. I'm not saying that every person with high blood pressure has a heart attack, but is it a risk -- is high blood pressure a risk factor for having a heart attack?
A Not on its own.
Q Okay. Are you suggesting -- are you reading this passage to mean that a person must have all of these conditions, in order for them to amount to a risk factor for a heart attack?
A No, no. Diabetes is considered a risk factor on its own. But I wouldn't say that just high blood pressure on its own would be a risk factor for a heart attack.
Q Okay.
A I think that someone that hasn't taken their blood pressure medicines have a risk for high blood pressure.
Q Okay. So you don't think that high blood pressure is a risk factor for a heart attack?
A Not on its own.
Q Okay. What would it need to be combined with

Page 96

to be a risk factor for a heart attack?
MR. MCCAULEY: Object to form.
A Some basis, some family history, some personal history, some -- I mean, just -- there are many, many people that have high blood pressure. Of those people that have high blood pressure, there's a very small portion of them that have a heart attack.
Q If someone had high blood pressure and congestive heart failure, would that put them at greater risk for a heart attack?
MR. KNOTT: Object to the form of the question. It's vague. Incomplete hypothetical.
A A history of congestive heart failure is multifactorial as well. You can have a history of congestive heart failure from -- that resolves and is a normal -- it's hypothetical and I can't answer.
Q Okay. Is a -- let me ask you a non-hypothetical question, which is congestive heart failure a risk factor for a heart attack?
MR. KNOTT: Object to form.
MR. MCCAULEY: Join.
A It can be a residual of a heart attack. Depends on the congestive heart failure.
Q Okay. If someone were to present to you -- well, strike that. I'm sorry, Ms. Pisney. Let me put

Page 97

this Exhibit 28 back up. After the first page that we were just looking at, you see what is a heart attack and who is at risk, right? Do you see that, Ms. Pisney?
A Yes.
Q Okay. The next page of Exhibit 28 says, "Know the symptoms of a heart attack," do you see that?
A Yes.
Q And it describes -- I'm going to zoom in here. If you want to read more of the document, that's fine. Just let me know. You see on the left hand column, it says, "Know the symptoms of a heart attack," do you see that?
A Yes.
Q Okay. The first symptom of a heart attack is chest pain or discomfort, do you see that?
A Yes.
MR. KNOTT: Object to the form of the question.
Q Do you agree that chest pain or discomfort is a symptom of a heart attack?
A It can be.
Q A symptom -- and just so we're clear, a symptom doesn't mean you definitely have something or you definitely don't. It means it's a symptom, as in, a possible cause of a symptom is the underlying condition,

Page 98

which in this case we're talking about a heart attack, right?
A It can be a symptom of a heart attack. Yes.
Q Okay. So that's -- one of the symptoms of heart attack is chest pain or discomfort; is that right?
A Correct.
Q Okay. The next sentence, it says, "Most heart attacks involve discomfort on the center or left side of the chest." Would you agree with that?
A It would -- it just depends on the person, but I guess, that's a common symptom.
Q Okay. The next sentence says, "The discomfort usually lasts for more than a few minutes or goes away and comes back," do you see that?
A I do.
Q Would you agree with that?
A Yes. Very fleeting episodes of chest pain usually are not cardiac in nature.
Q Okay. If someone has chest pain and it goes away, does that mean that -- at a particular time, does that mean that they're no longer at risk for heart attack?
MR. KNOT: Object. Vague. Overly broad. Incomplete hypothetical.
Q Let me ask a different question, Ms. Pisney.

Page 99

Given the chest pain or discomfort associated with a heart attack can go away or come back. If a person is experiencing chest pain and then at a particular point in time, thereafter, they're not. Does that mean that they are no longer at risk for heart attack?
MR. KNOTT: Object to form.
MR. MCCAULEY: Join. Incomplete hypothetical.
A It could mean that it wasn't a symptom of a heart attack or it -- if it comes back, then it would be more serious. But if it goes away for hours at a time and doesn't come back, then I'd be less likely to suspect a heart attack.
Q Okay. You need to know that it was -- had gone away for hours at a time; is that right?
A I mean, if it's -- it's unknowable.
Q What do you mean by that, Ms. Pisney?
A I don't -- I mean, if someone has chest pain and it goes away, that could be they had gas. And if it never comes back, then it's unlikely to be cardiac.
Q Okay. You mean, "It never comes back," any point, thereafter, right?
A I don't know if -- I mean, chest pain separated by years wouldn't necessarily lead me to think that people were having a heart attack.
Q How about chest pain separated by a few hours?

Page 100

MR. KNOTT: Object to form.
A Again, we're -- that's hypothetical. This case, she had chest pain once.
Q If -- okay. Another symptom of chest pain listed here is, "Upper body discomfort," do you see that?
A That's a symptom of a heart attack that they list.
Q Okay. And one of the symptoms is, "Pain in the shoulders," do you see that?
A Yes.
Q Would you agree with that, as a symptom of a heart attack?
A Sometimes chest pain radiates to the shoulder, as a symptom of a heart attack.
Q Okay. Another symptom that this publication identifies is, "Shortness of breath," do you see that?
A I do.
Q Okay. And it says that, "This may occur" -- referring to shortness of breath as a symptom of a heart attack. "This may occur, be your only symptom, or it may occur before or along with chest pain or discomfort," do you see that?
A Yes.
Q Would you agree that shortness of breath that

Page 101

occurs before or along with chest pain or discomfort, is a symptom of a heart attack?
A It could be.
Q Meaning that it's a symptom of a heart attack, that as a potential -- that's a symptom indicating that it's a potential cause the -- strike that. When you say it could be, you mean that's a cause of that symptom that you would need to rule out because it's a potential heart attack causing the symptom; is that right?
A I -- if someone presented to me with shortness of breath, that's not the first thing that I would think about. No.
Q How about if -- okay. So just -- if it was shortness of breath that occurs before chest pain, is that, to you, a symptom of a heart attack that would want -- cause you to want to rule out heart attack, as a cause for those symptoms?
A In a person with asthma? No. I'd be more likely to -- to think it's related to the asthma, could also be related to anxiety, panic attack.
Q Okay. That'd be a possibility, right?
A Yes.
Q And would that be something you'd want to rule out?
A The panic attack or the asthma?

Page 102

Q Sure. Well, let me put it this way. If someone has asthma, that's potential shortness of breath followed by chest pain. Are you saying that -- are you -- let me back up. We're referring just here to shortness of breath, right? So if you're saying -- if I understand you correctly, you're saying that shortness of breath could just be a sign of asthma, right?

A Could be, in a -- especially in a person that has asthma.

Q Okay. And if there's shortness of breath, that's followed by chest pain, is that a symptom of asthma?

A It depends. I mean, they -- albuterol can cause you to have racing heart. If you've taken albuterol for your shortness of breath, that could be associated with some chest pain, I suppose.

Q Would another cause of shortness of breath followed by chest pain, be a heart attack?

A It's possible.

Q Is that a possibility that you would want to rule out in your differential diagnosis?

MR. KNOTT: Vague. Overly broad. Incomplete hypothetical.

A There are -- it's -- I -- you know that you can't just throw some symptoms at me, and have me make a

Page 103

diagnosis based on those, without a specific patient and the -- everything that goes along with that patient.

Q If a patient presented to you with shortness of breath, followed by a heart attack, would you want to rule out -- or -- I'm sorry, strike that. If a patient presented to you with shortness of breath followed by chest pain, and that was their medical history, would you run to rule out heart attack, as a potential cause for those symptoms?

A Those are symptoms of a heart attack. They could also be other -- symptoms of something else.

Q Okay. And if they are symptoms of a heart attack, you would want to ensure that you had ruled it out, correct?

MR. MCCAULEY: Object to the form of the questions. Vague. Overly broad. And incomplete hypothetical.

A You can't always rule everything out immediately.

BY MR. WEIL:

Q Okay. Would you want to attempt to rule it out?

MR. MCCAULEY: Vague. Overly broad. Incomplete hypothetical.

A Again, it depends on situation that you're in.

Page 104

Q What do you mean by that?

A There are so many options for these symptoms to show up and in dealing with patients, you have to take each patient individually, give the information that you have at that time, and then make a decision.

Q If you received a call saying, this patient has chest pain be -- well, this chest patient has chest pain, before that they had shortness of breath and that's the call you received. What else would you want to know, in order to rule out the possibility of heart attack?

A I would want to know how old they were, when the chest pain occurred, were they at rest, were they in activity, did they have any other symptoms, what were their vital signs, what medications were they on?

Q Would any of the things that you just listed rule out the possibility of heart attack?

A Usually chest pain at rest is not a cardiac in nature.

Q Is it possible that it's cardiac in nature, if someone's having a heart attack?

A Be less likely.

Q Can people at rest have a heart attack?

A I suppose they could.

Q Okay. So the fact that a person was at rest

Page 105

-- and experiencing the symptoms of shortness of breath followed by chest pain, the fact that they were at rest would not rule out a heart attack; is that right?

MR. KNOTT: Object to form.

A I would be less likely to think of heart attack as a potential, if it happened at rest.

Q Okay. Is it one of the conditions that you would make to sure you'd want to rule out, though?

MR. KNOTT: Object to form.

A When -- I've answered this previously, the chest pain is a symptom of heart attack, and you'd want to rule out a heart attack.

Q Sure. We're talking here, you said, if someone was at rest and experiencing these symptoms, you think a heart attack would be more likely, so I'm asking about that. So if someone's at rest --

A Less likely.

Q Less likely-

MR. KNOTT: Did you hear her?

Q Yes. All right. If I understand you correctly, if someone's at rest, and you are alerted that they have shortness of breath followed by chest pain. If I understand you correctly, you think it would be less likely that they would have a heart attack than if they'd been active; is that right?

Page 106

A Yes.
Q Okay. Nevertheless, is heart attack a cause of those symptoms that you would want to rule out in your differential diagnosis?
MR. KNOTT: Vague. Overly broad. Incomplete hypothetical. Go ahead.
A I answered that previously.
Q Do you remember the rule to be laid out at the beginning of this deposition. Which is if, unless your lawyer instructs you not to answer a question, you're obligated to answer it. I'm asking you to please answer that question.
MR. KNOTT: And --
A And I said --
MR. KNOTT: Mr. Weil, I'm going lay out a rule too. Which is please don't instruct my clients on how to answer questions. So she's entitled to stand by her prior answer to that. And if she'd like to do that, she can answer the question again.
A As I said previously that I stand by that answer. I mean, I've answered this question multiple times.
BY MR. WEIL:
Q Ma'am, I don't believe you have. We have not -- but are you refusing to answer this question?

Page 107

MR. KNOTT: She's answered it.
MR. MCCAULEY: Object to form.
Mischaracterizes.
BY MR. WEIL:
Q Okay. Let me ask it again. Just so we're clear on the record. You stated that if someone presented to you with shortness of breath followed by chest pain and they had been at rest. It would be less likely that they were experiencing a heart attack in your mind, correct?
MR. KNOTT: Object to form.
MR. MCCAULEY: Vague. Speculative.
A That is what I said. Correct.
Q Okay. And my question to you was, nevertheless, would you want to rule out heart attack as a potential cause of the -- those two symptoms of someone who you learned was at rest?
MR. MCCAULEY: Same objection.
MR. KNOTT: Same objections. Asked and answered, multiple times.
A As I said, shortness of breath and chest pain symptoms of a heart attack and you would want to rule out a heart attack. I've said that many times.
BY MR. WEIL:
Q Even for someone at rest, who you believed --

Page 108

for whom you believed a heart attack was less likely, correct?
MR. MCCAULEY: Object to form.
MR. KNOTT: Can I -- asked and answered, multiple times.
A You have to take everything into consideration when you're deciding, and chest pain at rest is less likely to be cardiac in nature.
BY MR. WEIL:
Q Does that mean that you would not rule out heart attack for someone who is at rest?
MR. KNOTT: Object to form.
MR. MCCAULEY: Object to the form of the question. Vague. Incomplete hypothetical.
A I'd have to take other things into consideration.
BY MR. WEIL:
Q What else would you take into consideration?
A Any other symptoms that they were having, any history, any family history, any previous diagnoses, any medications.
Q If someone -- so which of those things would rule out heart attack, as a cause for the symptoms of someone who's experiencing shortness of breath, followed by chest pain, who's at rest?

Page 109

A They have a prior diagnosis of heartburn. If they have no family history or personal history of heart attack. If they are not on any medications for heart medications. If they're young and healthy.
Q It would be critical --
MR. KNOTT: Counsel, we've been at it an hour-and-a-half. And we need to take a short break or a little more extended break, but I'd like to have a break fairly soon. We've been at it a long time.
MR. WEIL: Sure. We can take a break right now. Would we like to do lunch?
MR. KNOTT: Let me talk to the witness briefly.
MR. WEIL: Okay.
THE WITNESS: Like a half hour.
MR. KNOTT: Yeah. I think like 20 minutes to a half hour would be good.
MR. WEIL: Let's let's come back at 1:30.
MR. KNOTT: Okay.
MR. MCCAULEY: All right.
MR. KNOTT: Sounds good.
MR. WEIL: Okay.
COURT REPORTER: We're off the record. The time is 1:00 p.m.
(OFF THE RECORD)

Page 110

COURT REPORTER: We are back on the record for the deposition of Lisa Pisney being conducted by video conference. My name is Sydney Little. Today is March 3, 2022. And the time is 1:38 p.m.

MR. WEIL: Good afternoon, Ms. Pisney, were you able to get lunch?

THE WITNESS: Yeah. Thank you.

MR. WEIL: Great. I hope you're rested and ready for some more questions. I'll try to move this along as fast as I can.

BY MR. WEIL:

Q I want to refer you back to Exhibit 29, which we were discussing before lunch. Do you recall that we spent quite a bit of time on this bullet here. Can you see it in front of you, Ms. Pisney?

A Yes.

Q Okay. We spent quite a bit of time on this bullet, shortness of breath. You see below that the shortness of breath bullet, it says, "Other possible symptoms of a heart attack." Do you see that?

A Yes.

Q Okay. So nausea is another possible symptom of a heart attack; is that right? According to this document?

A Yes.

Page 111

Q Would you agree that you should pay attention to nausea as another possible symptom of a heart of a heart attack?

A Yes. But also symptom of many other things.

Q Okay. One of those things could be a heart attack, correct?

A Yes.

Q Especially if it were combined with other symptoms like chest pain, or discomfort, or shortness of breath; is that right?

A It's one of the possibilities.

Q And in the differential diagnosis, that would be all the more reason to exclude heart attack as a cause of such a symptom?

MR. KNOTT: Object to the form of the question. Vague. Overly broad. Lacks foundation. Incomplete hypothetical.

MR. MCCAULEY: Answered.

A It would be part of the things that I would take into consideration.

BY MR. WEIL:

Q You see below nausea, it says, "Lightheadedness or sudden dizziness," do you see that?

A Yes.

Q And that's another -- you would agree that that's another possible symptom of a heart attack?

Page 112

A Yes.

Q Okay. If we go the right hand column of the second page of Exhibit 29, I'll start you at the top and scroll down -- I'm sorry. You see it says here, "Heart attacks don't always cause common symptoms," do you see that?

A Yes.

Q And there's a paragraph, take as long as you like to read it. I'm interested in the first bullet underneath that paragraph.

A Yes. I've read it.

Q Let me know when you're ready. Okay. It says there that, "Heart attacks can start slowly and cause only mild pain or discomfort," right? Do you see that?

A It says that, they don't always begin with a sudden crushing chest pain.

Q Where are you, Ms. Pisney?

A The beginning of the --

Q Sure. Go ahead. I'm sorry.

A At the beginning of the paragraph.

Q Okay. You're up here with, "Not all heart attacks," up here?

A Right. And then -- I see where you're talking about the first bullet.

Page 113

Q Right. I'm talking about this first bullet. So it says in the first bullet, "Heart attacks can start slowly and cause only mild pain or discomfort," do you see that?

A Yes.

Q Would you agree with that?

A It's possible.

Q It's possible you agree, or it's possible that that is a course of symptoms of a heart attack?

A It's possible that that might be a symptom of a heart attack.

Q Okay. The second sentence says, "Symptoms can be mild or more intense and sudden," do you see that?

A Yes.

Q Would you agree that sometimes, heart attack symptoms can be mild or more intense and sudden?

A Yes.

Q Okay. And the last sentence in that first bullet says, "Symptoms also may come and go over several hours." Would you agree that symptoms of a heart attack may come and go over several hours?

A That's possible.

Q Okay. Do you -- by that, do you mean it's possible that you agree or possible that symptoms of a heart attack may come and go over several hours?

Page 114

A It's possible that symptoms may come and go over several hours.
Q Turning you to the third page of Exhibit 29. You see this column on the left says, "Quick action can save your life. Call 911"?
A Yes.
Q I'm interested in the third bullet down where it begins, "The 911 operator," do you see that?
A I see something, but I can't read it.
Q Okay. I'll zoom it in. Does that help you?
A No.
Q Can you read it now?
A Pull it out a little bit. Yep.
Q Okay. Says -- just take a look at this bullet, and then I have a question about the last sentence
A I read it.
Q Okay. It says, "Aspirin taken during a heart attack can limit the damage to your heart and save your life," do you see that?
A Yes.
Q Okay. And the next bullet is in bold, where it says, "Every minute matters," do you see that?
A Yes.
Q Okay. To back up real quick, would you agree

Page 115

that aspirin taken during a heart attack can limit the damage to your heart?
A It can help.
Q Okay. In the next bullet down it says, "Every minute matters. Never delay calling 911, to take aspirin, or do anything else you think might help," do you see that?
A Yes.
Q Would you agree that one should never delay calling 911, to take aspirin, or do anything else that they think might help, when they're experiencing the symptoms of a heart attack?
MR. KNOTT: Object to vague. Overly broad. And incomplete hypothetical.
A That would be, if you knew you were having a heart attack.
Q Okay. If you believed that -- well, if someone was exhibiting the symptoms of a heart attack, would aspirin be a way to treat those symptoms and -- therefore, in the differential diagnosis?
A You can use aspirin to help with the -- slow the blood clotting and that would help in a heart attack. But you can also use aspirin as an anti-inflammatory for -- for musculoskeletal pain, anti-inflammatory for other types of pain.

Page 116

Q Is aspirin a way of treating a heart attack?
A It's one of the medications given.
Q Is it an effective means to treat a heart attack?
MR. MCCAULEY: Object to form.
A It wouldn't be the only treatment.
Q Okay. So aspirin alone would not be sufficient to treat a heart attack; is that correct?
MR. KNOTT: Object to form of the questions. Vague. Overly broad. And incomplete hypothetical.
A You would need to do more, if you were having a heart attack.
Q Going to show you now a document we'll mark as Exhibit 30. This is a publication by Healthline and I'll page through it real quickly for you, Ms. Pisney. It's five pages long it's titled, "Blood Pressure Changes During a Heart Attack." I'm interested in the line here, in the second paragraph. Can you read it Ms. Pisney or should I zoom in a little?
(EXHIBIT 30 MARKED FOR IDENTIFICATION)
MR. KNOTT: I think you need to zoom in.
A Zoom in.
Q Okay. Is that any better?
A Yes.
Q Okay. It says, "Any blood pressure changes

Page 117

that may occur during a heart attack are unpredictable, so doctors generally don't use them as a sign of a heart attack," do you see that?
A Yes, I do.
Q Would you agree that blood pressure changes during a heart attack are unpredictable?
A I would.
Q Would you agree that blood pressure changes shouldn't be used to rule in or rule out a heart attack?
MR. MCCAULEY: Object to form.
A That's true. That's what I've said previously, that not everybody with high blood pressure has a risk for heart attack. Some people with heart attacks will have low blood pressure.
Q Right. And so this is -- this -- do you read this sentence as referring to, blood pressure changes during a heart attack?
A That's what it says. Yes.
Q Okay. And so a doc -- you agree that during -- while someone's experiencing symptoms that are -- that may be a heart attack, you would not rule out a heart attack by using blood pressure measurements?
MR. MCCAULEY: Object to form -- sorry. Object to form.
MR. KNOTT: Join.

Page 118

A Yeah. I -- blood pressure wouldn't play a indicator in my judgment of that. No.
BY MR. WEIL:
Q I want -- we talked about your independent memory of the time that Christine Boyer was in the jail. I want to ask you a few questions by directing you to documents this time. And just --
A Okay.
Q -- go over the course of events there. So do you -- well, we'll get there. I was going to ask your lawyer to show you some documents -- or if he has any, but we'll wait. We've done that in the last deposition, but we don't need to yet. The first document I want to show you, Ms. Pisney, is Exhibit 3, and it's the intake medical screening report. I believe it's a document that you reviewed in preparation for your deposition. I'm going to pull it up on the screen right now, and you tell me if you've seen it before. So can you see a document in front of you?
MR. KNOTT: I'm going to give her a paper copy, if she wants to refer to that.
MR. WEIL: That'd be great. Thank you, Doug.
A Yes. I see it.
BY MR. WEIL:
Q And is this a document you referred to, in

Page 119

preparation for your deposition today -- or reviewed?
A I did. I did -- I did review it. Yes.
Q Okay. I want to direct you to the first call that you remember receiving about Ms. Boyer. And I believe you said it was before there were the calls about high blood pressure. Okay?
A Yes.
Q You -- I believe you told me, that you received a call about someone with medical issues and -- sorry. I'm just looking back at my notes here. It said she was -- the call was that she was unable to tell Amber Fennigkoh what all the meds she was on, and it -- she was unable to provide a reliable medical history. Do you remember that from this morning?
A Correct. Yes.
Q Okay. When -- would your practice have been to gather all the information that you could at that point, about the person?
A Yes.
Q Okay. Do you remember asking -- or would you have -- let me ask you this, that you also recall being called either during that call or possibly in a separate call about medications that she might be on?
A I must have. Although, I don't remember that.
Q Okay. I'm looking down here at the bottom of

Page 120

Exhibit 3, on page 1093. You see there's an asterisk right at the bottom, on the last page of-
A Yes.
Q -- the exhibit? And it says, "Medical call Medicine Shoppe Monday to get med list, plus get her records from hospital, per Pisney," do you see that?
A Yes.
Q Does that refresh your recollection at all, as to any conversation you might have had about Ms. Boyer, in that first set of calls before -- call or calls before the high blood pressure call?
MR. MCCAULEY: Object to form.
A That would've been --
MR. MCCAULEY: Yeah.
A That would've been my instructions to them, to get more information. We weren't able to get her medicines from the pharmacy because they were closed, and we didn't have any reliable medical history. So I had instructed them to get her medical records, so we could get that.
Q Okay. And in your practice, would you have asked the person who called you to read off any documents, reporting whatever medical history that she did have?
MR. MCCAULEY: Object to form.

Page 121

A They wouldn't read -- they wouldn't have read this in verbatim to me. No.
Q Would -- when you say verbatim, what do you mean?
A They don't go through every one of these questions and tell me what she answered.
Q Okay. I want to take you to the first page of Exhibit 3.
A Uh-huh.
Q It said -- you recall someone reporting that Ms. Boyer said she had a month to live, do you remember that?
A Yes.
Q Do you see number two here -- item two, "Are you sick or injured in any way?" And this document says, "Some doctors say I have a year to live," do you see that?
A Yes.
Q Is that what you might have been told is report -- what might have been reported to you?
MR. MCCAULEY: Object to form. Calls for speculation.
A I --
MR. KNOTT: Object to form. Foundation. Speculation. And the question's vague, as to time.

Page 122

Q Sure. I'm talking about this first call that you got, before the calls about high blood pressure.
A I seem to remember someone telling me that she had said a month to live, but...
Q Okay. When you get a call like that, what is your practice, in terms of trying to gather information from the caller?
MR. MCCAULEY: Object to form.
Q Well, you get calls all the time from people -- well, I think you said multiple times per week for Monroe County, correct?
MR. MCCAULEY: Object to form.
A Sure.
Q And I believe it was -- I had one call per day, roughly, from Monroe County Jail, right?
A At least one call per day.
Q And you're getting those calls -- typically those calls would be coming from correctional officers. Is that right?
A No. Most of the calls I got were from the nurse.
Q Okay.
A And then occasionally, the nighttime calls would've been from correctional officers.
Q Okay. And the weekend calls as well?

Page 123

A Yes.
Q Okay. And when you got calls from correctional officers, they may have had -- to your knowledge, they would've had some medical training, but maybe not as much as a nurse?
A Yes.
Q Okay. Did you have a technique to elicit relevant medical information from officers as they called?
A Yeah. I asked them questions about any symptoms, or the patient that they were calling me about.
Q Do you typically ask the person who's calling you to read off any notes about the person's medical history or medical conditions?
A I sometimes will ask that. But not always.
Q Okay. Would you want to know anything important that had been written down about a person?
A Yes. But I don't always know what they deem important.
Q Yeah. That was a vague question. I'm sorry. Anything important medically -- would you want to know anything important medically, that's been written down about a patient?
A I would. But I can't be sure that I always

Page 124

get it.
Q Okay. And so what -- given that you can't be sure that you're always getting what's medically important. What's your technique in terms of asking guards to report medical information, that's been written down about a patient?
A Usually, I just ask them questions that I want to know in making a judgment.
Q Would you start with a question, is there anything written down about the patient?
A No.
Q Okay. So you wouldn't -- would you ask them, do you have a medical history for this patient?
A For this patient in particular, I wouldn't have. Because I've been told previously that we didn't have her medical history.
Q Do you have any idea why you were called about a patient who had no medical history?
A They called to let me know that she'd been admitted. And that this call must have been asking me about her medications that she had on person.
Q Okay.
A And then they told me that they did not have a medical history and they did not know her medications. And I that's when I told them to get that information.

Page 125

So we were in the process of trying to get that information.
Q Okay. What you recall her -- them telling you, is that she reported she had a month to live?
A Yes.
Q Would that prompt you to try to gather as much medical information you could about this person?
A It made me skeptical about the reality of that statement. But I didn't have any information to base it on.
Q When someone expresses that they're very ill or sick, do you -- are you -- do you have a way of ruling out that they're malingering or exaggerating their symptoms?
A That's why I ask them certain things about, you know, when the symptoms started, any other symptoms that go along with it, to see if it makes sense medically.
Q And when you are remote and it's a guard calling, you're typically not able to ask the patient themselves, right?
A No. I don't speak with the patient.
Q Okay. So do you try to gather as much information like that, about their symptoms and their history from the guard?

Page 126

A I do.
Q Okay. And so when you're trying to gather that information, do you ask the guard if there's anything written down about the person or symptoms?
A No. I'm just assuming they're telling me everything there is to know.
Q Okay. So you don't say when some -- when a guard reports that someone says something like, I have a month live, you would ask -- do you know -- it'd be your practice to say, well, do you know anything else about this person, right?
A I probably would've said, why -- why did she say that -- why? Did she give a reason?
Q Okay. And would you also want to say, just tell me what you know about this person's medical history -- or what she said about her medical history?
A They've already told me that they didn't know her medical history. She wasn't able to give a clear medical history.
Q Would someone with this form who'd written down exhibit -- you went over Exhibit 3 in preparation for this deposition, right?
A I did.
Q Okay. Would someone on this form -- look at, if you would, at page 3, which I have up on the form

Page 127

here, under the notes. It says, "She states she has multiple medical issues due to cancer," do you see that?
A Yes.
Q So that's a medical condition, however vaguely described, that someone who had this form would know Ms. Boyer expressed, right?
A Yes. I do remember them saying that she said she had cancer.
Q Okay. And right after, it says she's on chemo -- or it says, "Chemo/radiation," right?
A Yes.
Q So that would be another piece of medical information that the person who had this form would have?
A I'm assuming. Yes.
Q And the next line says, "Also states she has congestive heart failure," do you see that?
A I do see it.
Q So that's another piece of information that this person would have, right?
A It's written.
Q Okay. And I guess, again, do you have any reason to think that when you got a call, the person who called you didn't provide you this information?
A I don't remember ever getting information that

Page 128

she had congestive heart failure.
Q Okay. Do you have any reason to think that a person calling you about Ms. Boyer's medical history would not have provided you with that information?
MR. KNOTT: She just answered that question. She told you her recollection.
Q I -- that wasn't what my question asked.
A As I said, they don't read that verbatim to me. They tell me what they think is important, and what the high points are, but they don't go through everything verbatim.
Q Do you think any person reading this form would not think the congestive heart failure is important to let you know about?
MR. MCCAULEY: Object to form.
MR. KNOTT: Foundation and speculation -- foundation and speculation.
A I -- I don't recall them ever telling me she had congestive heart failure.
BY MR. WEIL:
Q My question was different. Do you think any person who read you this form, and was trying to provide you medical information about Ms. Boyer's medical history, would not think the congestive heart failure was something important to tell you?

Page 129

MR. KNOTT: Foundation. Speculation about the frame of mind of specific correctional officers.
A I don't -- I mean, I have no idea why they wouldn't tell me, but I don't remember them telling me that.
Q You don't remember one way or the other, right?
A I don't --
MR. KNOTT: She's answered the question.
A I specifically don't remember them saying that she had congest heart failure.
Q Do you remember, one way or the other, whether they told you that?
A I remember them telling me that she said she had a month to live, that she'd had cancer, but I don't remember anything about congestive heart failure.
Q Okay. Ms. Pisney, I'm going to showing you another document. I'm going to try to make it a bit more manageable. This is Exhibit 18. Do you recognize this document as something you reviewed in preparation for this deposition?
A Yes.
MR. KNOTT: Take a second to get her a paper -- paper copy.
MR. WEIL: Sure. That'd be great, Doug. Thank

Page 130

you.
A I have it.
BY MR. WEIL:
Q Okay. Let me -- just real quickly, Ms. Pisney, I want to close out Exhibit 3, just a couple more questions. We talked about congestive heart failure. So we're looking at Exhibit 3 again. The -- on page 2 of Exhibit 3, you see line 14. It also says -- it lists a bunch of conditions. One of them is high blood pressure, and one of them is asthma?
A Yes.
Q You see that?
A Yes.
Q Do you have any reason to think that a guard calling you to report on Ms. Boyer's medical history, would not have reported that Ms. Boyer had been treated for high pressure and asthma?
MR. KNOTT: Object to form.
A I don't remember them telling me those, either.
Q Okay. And again, I think you said when you heard that Ms. Boyer reported that some people had said she had a month to live, your practice would be to try to gather as much information as possible from the person calling, right?

Page 131

A That's why I asked them to get her medical records and her prescriptions.
Q Would you ask -- and I think you also said that one of the things you would do, is ask the person to provide any medical information that they were aware of at the time that was written down; is that right?
A No. I never specifically asked that. I assumed that when they're calling me, that they're going to give me the information that they have.
Q So if someone -- if a guard calls and reports that this patient who's come and says, I have a month to live. Would you the guard, did the patient say why? Would that be a question you'd ask?
MR. MCCAULEY: Object to form.
A That's possible. I likely did that. Yes.
Q Okay. And is it also likely that you would've said, well, did the patient identify any medical problems they have? Is that something you would've asked or, you know, something along those lines?
A They're calling me with their medical problems and they're telling me that they did not get a clear medical history from her. She did not know her medications. She said she had a month to live and that she'd had cancer. And that's really all I remember from that conversation.

Page 132

Q Again, do you have any reason to think that a person calling you, if they were reading from this form, would not have informed you about these reports of high blood pressure and asthma?
MR. MCCAULEY: Object to form.
MR. KNOTT: Object to the form -- object to the form of the question. She's told you her recollection.
A I don't know if they were reading from this form or not.
BY MR. WEIL:
Q Okay. But if they were, do you think they would've told you these things that were circled?
MR. KNOTT: Foundation. Speculation.
MR. MCCAULEY: Join.
A All I can say is what I remember, and I don't remember being told that.
Q Okay. Turning you back to Exhibit 18, I believe you have in front of you. I'm looking at the top line, which is for, Oxycodone. Do you see that?
A Yes.
Q And the medication instructions are in the second column of the sheet, correct?
A Yes.
Q Okay. And it says, "One tab, four times daily

Page 133

for pain," do you see that?
A I do.
Q Does that indicate to you that -- I understand that there's a, "Not approved," sign here, do you see that?
A Yes.
Q For the oxycodone. Does this indicate to you, however, that there was at least a written prescription for the oxycodone that was found with her?
A There -- yes. I believe so, because otherwise they wouldn't have known how she was prescribed it.
Q Okay. The second line is a drug -- I'm going to call it Zofran. I tried several times to pronounce it yesterday. But what's this drug here, Ms. Pisney? It's on line two.
A Ondansetron.
Q Ondansetron? And that's commonly referred as Zofran; is that right?
A Yes.
Q Okay. And here in this column, it says, "As needed for nausea from chemo/radiation," do you see that?
A Yes.
Q Again, I'm assuming just as these things are read, that would indicate to you that was a written

Page 134

prescription for this Zofran drug; is that right?
A I would assume so, since there's an indication or an instruction for their taking of it.
Q When -- you said that you recall earlier being called about the medications that had been found with Ms. Boyer; is that right?
A I -- I don't remember being called about the medications, but I must have been.
Q Okay. And is that -- are you saying you must have been, because part of your role at the jail was to -- as the provider, would be to approve medications like this?
A Yes.
Q Okay. And so -- and this would be -- this medication list would be medications that you were called about, that Ms. Boyer had on her person, right?
A Yes.
Q Okay. And so among other things, in approving this list, you would've learned that she'd been prescribed Zofran for nausea from chemo; is that right?
A Yes.
Q Or radiation, correct?
A Yes.
Q Chemo and radiation are treatments that are typical provided for a person suffering from cancer; is

Page 135

that correct?
A Yes.
Q Okay. So, would that indicate to you that Ms. Boyer had this prescription because she was suffering from cancer?
A It's possible. I don't know how old that prescription was.
Q You approved this medication; is that right?
A I did.
Q Would that indicate to you that when this prescription was communicated to you, that it was current?
MR. KNOTT: Foundation. Speculation.
A No. Not necessarily. These were the medications found on her person.
Q Would you have approved an out of date medication, like Zofran?
A Zofran is as needed for nausea. So if she had nausea, then we could use it.
Q Okay.
A So I don't -- I have no way of knowing what date it was. They usually tell me if they have a prescription bottle, what date it was filled, though.
Q Would that be over here, in this little line right here (indicating), on to the left of exhibit -- or

Page 136

line two?
A Yeah. Yes.
Q Can you tell me what that means, that that 65862391 --
A I do not.
Q -- and a 10. You don't know?
A No.
Q Would this indicate to you it was possible that Ms. -- this line from the Zofran, would that indicate that it was possible that Ms. Boyer was suffering from cancer, at the time she was booked into the jail?
A It's possible.
Q Okay.
A She did -- I mean, that's one of the things that she said, that I was understanding, that she said she had cancer.
Q So this prescription would corroborate her statement that she had cancer; is that right?
A If that was a current prescription. I don't -- in looking at her medical records from the hospital, I don't see any indication that she was being treated currently for cancer, but an old history of cancer. But that's -- I found that out afterwards.
Q Okay. At the time that you would've been

Page 137

called about this prescription here, the prescription for nausea, for chemo and radiation, would've corroborated Ms. Boyer's statement that she was suffering from cancer in your mind; is that right?
A Yes. If it was a current prescription.
Q Okay. And are you saying that you couldn't -- you can't tell from this line, whether or not it was a current prescription?
A I cannot.
Q So it was possible that it was a current prescription?
MR. KNOTT: Foundation. Speculation.
A Possible it was, possible it wasn't.
Q Okay. The next exhibit I'm showing you is Exhibit 20.
MR. WEIL: Doug, I don't know if you want to get this document for Ms. Pisney or not.
MR. KNOTT: Actually, I think that was marked first, yesterday. And I'm on the road, so I don't have paper copies of that.
MR. WEIL: Okay. Doug, are you referring to -- there's two versions of this, right? There's one that, like, was entered at an earlier time. I can use that one if you have that document document. It's --

Page 138

MR. KNOTT: Right. Exhibit 7 is the one that has the Eastern Time Zone.
MR. WEIL: Okay. Well, I'll just -- I'll pull up Exhibit 7.
BY MR. WEIL:
Q Okay. Ms. Pisney, do you have in front of you a document -- the same document that's up on the screen now, Exhibit 7?
A Yes.
Q Okay. Is this a document that you reviewed in preparation for your deposition today?
A I did see this. Yes.
Q Okay. This is an e-mail from Shasta Parker. Do you know who that is?
A Yes.
Q Who is that?
A She's one of the CO's in the jail.
Q Is Shasta Parker a CO who you spoke with from time to time, in fulfilling your job as the on call practitioner?
MR. MCCAULEY: Object to form.
A Yes.
Q Okay.
MR. KNOTT: Can we pause for just -- can we pause just for a second. I know you want to use

Page 139

Exhibit 7 to accommodate us, and I appreciate that. I think we should inform the witness, that to the best of our knowledge, this is actually a 6:26 p.m. Central Time, just so we're straight on that.
BY MR. WEIL:
Q Sure. So, Ms. Pisney, what he's -- what your lawyer's talking about, is this is one of the features of electronically stored information. You see this line up here that says, "December 22nd, 7:26 p.m."?
A Yes.
Q Okay. And then it says, "EST," afterwards?
A Yes.
Q We are figuring it out. But what we believe is that refers to Eastern Standard Time. And Wisconsin's Central Time, right?
A Correct.
Q And so there's another document that is identical in terms of its text, but it refers to 6:27 p.m. So an hour before. So I think we believe that this was written at 6:27 p.m.
A Okay.
Q Okay.
MR. KNOTT: Thank you.
Q Okay. So, I'll refer to Exhibit 7, just so we're all looking at the same document, with that

Page 140

understanding. And again -- I'm sorry, I'm going to violate Doug's rule and repeat the question. You do recall reviewing this document before your deposition today, correct?
A Yes. I did see this before.
Q Okay. So it begins, "Hello. Christine Boyer, as you know, has a number of medical issues," do you see that?
A Yes.
Q Okay. And it says, "This afternoon, she started complaining of feeling hot and sweaty and not being able to breathe," do you see that?
A Yes.
Q Okay. "She asked to take -- to have her blood pressure taken and it was 177 over," and it says, "I can't remember this bottom one at the moment, but it is on the MAR. It was really high. And we called Lisa," do you see that?
A Yes.
Q Is it consistent with your memory -- earlier today we discussed you receiving this call -- or one or two calls in the morning about Ms. Boyer's medical history and prescriptions, right?
A Yes.
Q And then you received a subsequent call -- you

Page 141

recall receiving a subsequent call about Ms. Boyer having high blood pressure?
A Yes.
Q Okay. Is the information here about this first call consistent with your recollection about receiving a call about Ms. Boyer having extremely high blood pressure?
A I do remember them calling me about the high blood pressure. I don't remember them telling me that she had complained of being hot, and sweaty, and not being able to breathe.
Q Okay. You don't remember one way or the other?
A I don't remember them telling me that. I just remember about the blood pressure.
Q Okay. Any reason to think they wouldn't have told you that?
A No. I just don't remember them saying it.
Q Okay. The next line after, "We called Lisa," says, "She said, give one dose of 0.2 milligrams of clonidine, and then do a blood pressure check at 3:45 p.m.," do you see that?
A Yes.
Q Is that consistent with your recollection of this first call about high blood pressure?

Page 142

A Yes. I gave -- I told them to give her 0.2 of clonidine and recheck her blood pressure in half an hour.

Q Okay. The next line says, "The recheck was 196/106, and Lisa said to recheck it again," do you see that?

A Yes.

Q Okay. And so I'm assuming this means that there was a second call that was made to you, to recheck it again. Is that how you read that?

A Yeah. So they called me at 3:45 to tell me the recheck, and it was coming down, so I wanted them to check it again in an hour before we did anything else, so we didn't drop it too much. And then if it was above the 160 over 100, to give her another dose of clonidine.

Q Let me slow you down and take that in some pieces. So -- is what you just testified, is that your independent recollection or is that what you're inferring from this document?

A No. That's my recollection. I do -- I do remember them calling me about her blood pressure. I always thought it was one call, but obviously, from the paperwork and this e-mail, it was two calls, actually.

Q Okay. And so your practice here was when you reported high blood pressure, give some medication, call

Page 143

back in a half hour, if it's still high, right?

A Yes.

Q Okay. And So there's a call at 3:45 p.m. And it's 169 over 106, right?

A Yes.

Q Okay. And then the next line is, "Lisa said, recheck it in an hour. And if the bottom number is still over 100, or a blood pressure reading such as 169/100, then go ahead and give her another 0.1 milligram of clonidine," do you see that?

A Yes.

Q Okay. Okay. Did you provide any further instructions after that, about what to do after an hour?

A Well, I told them if it was over that -- that amount, then give her another 0.1 Of clonidine.

Q Right.

A But no. Other than that, no.

Q Is there a reason that you didn't instruct them to see if that last 0.1 milligram of clonidine -- so just to back up. After instructing them to say, give them that one last 0.1 milligram of clonidine, you didn't instruct them to check her blood pressure again, to see if that quantity had been successful in reducing her blood pressure?

A No. The 0.2 clonidine was working, so another

Page 144

0.1 was likely to work. I didn't instruct them to recheck our blood pressure. No.

Q Is there any reason you would not want them to check and confirm, that last 0.1 milligrams of clonidine was successful in actually reducing her blood pressure?

A I didn't -- I didn't instruct them. It's typical that it looked like it was working. So another 0.1 would make it drop even further. And I think that would've been in the normal zone. So I didn't instruct them to check, but if she'd had symptoms, they would've rechecked her.

Q What are the symptoms of high blood pressure, besides high blood pressure?

A Well, she was complaining and feeling hot, and sweaty, and not feeling right, or being able to breathe when she asked it for it to be checked, originally. So she had a symptom, and she asked that her blood pressure be checked.

Q Was there any protocol for someone complaining of high blood pressure and having -- being hot, and sweaty, or not being able to breathe at the jail?

A No.

Q Okay. So were you -- why -- it sounds like you assumed that the guards would know when to identify concerning symptoms, after this 0.1 milligram of

Page 145

clonidine?

A I mean, typically, we're not doing vital signs on every inmate at any certain time.

Q Is -- was there any reason not to just ask the guards to check again, and see if that last 0.1 milligrams of clonidine and had been successful in actually lowering her blood pressure?

MR. KNOTT: That's been answered.

A I -- doesn't -- it doesn't appear that I asked them to recheck. I don't -- it was working, and I assumed that the next dose would drop it even further, and get it her into the normal zone.

Q And you weren't asking the guards to confirm your assumption?

A I was not.

Q Why not?

MR. KNOTT: Asked and answered.

A I didn't judge it to be necessary.

Q Why not?

A It was my judgment.

Q Well, how did you reach that judgment?

MR. KNOTT: It's been asked and answered.

A As I said, the -- the first dose helped and the second dose, I assumed, would help as well.

Q Were you positive?

Page 146

MR. MCCAULEY: Form.
A No one's ever positive.
Q Okay. Do you remember what you were doing on Sunday, the 22nd of December?
A I was home.
Q You were home all day?
A Yes.
Q Were you getting ready for Christmas?
A I could have been. I don't remember exactly what I was doing, but I know I was home all day.
Q Okay. Do you attend church services in the morning -- is it your habit to attend church services in the morning?
A No.
Q Okay. Do you recall having any plans around the Christmas season, that you might have been doing on the 22nd of December?
A No.
Q Were you having any family over, on the evening of the 22nd of December?
A I don't remember.
Q Could we look at -- if you did, who would that be?
A I -- it could have been my family, my husband's family. I don't know.

Page 147

Q Was it your habit to celebrate around the Christmas season with family?
A Yes.
Q Your habit to have them over to your house, maybe for dinner?
A Sometimes. But --
Q Is there a -- go ahead, I'm sorry.
A We sometimes go to other family members' houses.
Q Is it possible that on the 22nd of December, you were over at someone else's house?
A No. I was home.
Q Okay. Do you remember anybody who was home with you that day?
A I'm sure my husband was.
Q You mentioned you have a daughter as well?
A Yes.
Q Does she live at home with you?
A No.
Q Okay. Any other children?
A No. My children are grown.
Q Okay. Would anybody have been -- any of your children have been visiting you on that weekend before Christmas?
A I don't believe so.

Page 148

Q Is there a way we could -- were you taking off work that week?
A I can't remember.
Q Okay. Your day job, at that point, would've -- your full-time job would've been at Gundersen Health; is that right?
A Yes.
Q Is there a way you could go back and identify whether you were taking that week off?
A No. I no longer work at Gundersen so -- I mean, Sunday I wasn't at work. Monday was the 20 -- no. It would've been the 23rd. I don't know if I worked that day beforehand. I probably did, before I went into the jail that night -- that evening. I usually work that day and then that evening, went into the jail.
MR. KNOTT: Referring to the 23rd?
THE WITNESS: Yes.
Q Okay. Again, I may have asked this and I apologize if I have. Where -- do your adult children live close by, where they might be coming over for dinner on the weekend during Christmas time?
A No. My daughter lives in Iowa and my son lives in Virginia.
Q Okay. Do you recall anybody coming in to visit you that weekend -- or you and your husband that

Page 149

weekend for Christmas?
A I don't remember. I don't know if we had family over or not.
Q Is there a way we could tell? Do you typically e-mail with family, we might be able to tell who was coming over, if anybody?
A No. We don't e-mail.
Q If someone was --
A Not that anybody remembers two years ago.
Q If someone was coming in from out of town -- would you have possibly exchanged e-mails to set that up or just arrange things?
A No.
Q Do you keep a personal calendar at all, Ms. Pisney?
A No. Not really. I have a calendar on my phone, but I don't put personal things in it, other than, like, hair appointments and things like that.
Q Is that -- how long have you had your phone?
A Several years.
Q Okay. Would you -- do you have the same phone you had in December 2019?
A I think so.
Q Okay. Do you have it with you?
MR. KNOTT: No. We're not going there.

Page 150

MR. WEIL: Okay.
MR. KNOTT: We're not going there. That's not a requirement for a deposition. A deposition is question and answer. If you want to do discovery, we can talk about it, but we're not going down that road.
BY MR. WEIL:
Q Okay. Is there anything -- beyond your lawyer's instructions, is there anything to stop you from just picking up your phone, and looking if you had anything scheduled on December 22, 2019?
A No.
MR. WEIL: Okay. Doug, are you instructing the witness not to -- we can just take a break --
MR. KNOTT: No. I'm instructing her --
MR. WEIL: -- for 20 minutes and just have her --
MR. KNOTT: I'm instructing you to -- well, I'll talk to her at the next break. But I'm instructing you, that we're going to follow the rules of civil procedure and you can ask questions. But we don't perform tracks, and we don't do research during a deposition for you.
MR. WEIL: Okay. How about we just take a quick break and you can talk to your client about

Page 151

it. And we can come back and at 2:40?
MR. KNOTT: What is your question?
MR. WEIL: I want to -- I'm trying to figure out what she had scheduled on December 22, 2019. The reason being, that -- well, that's -- I'm trying to figure out what she had scheduled, if anything.
MR. KNOT: Bearing in mind -- bearing in mind, that she testified that she was home all day.
MR. WEIL: I believe she doesn't exactly --
MR. KNOTT: (inaudible)
MR. WEIL: Sure. She doesn't exactly recall if -- her phone may be a blank and there be may be no answer one way or another. I'm just asking for her to just take a minute, and look at her calendar, and just tell me. If there's anything on there, there's something on there. If there's not, there's not. That's all I'm asking.
MR. KNOTT: We'll take a break.
MR. WEIL: Okay. Let's go back at 2:40, thanks.
COURT REPORTER: We're off the record. The time is 2:35.
(OFF THE RECORD)
COURT REPORTER: We are back on the record for

Page 152

the deposition of Lisa Pisney being conducted by video conference. My name is Sydney Little. Today is March 3, 2022. And the time is 2:41 p.m.
BY MR. WEIL:
Q Ms. Pisney, did you have a chance to look at your phone?
A I did. There's nothing on my calendar that day.
Q Okay. That day you're referring to is 22nd of December 2019, right?
A Yes.
Q Okay. Did you happen to see any indication of whether you were otherwise on vacation that week, understanding that you went into the Monroe County jail?
A No. No indication.
Q No indication one way or the other?
A Correct.
Q Okay.
MR. KNOTT: And for the record, her calendar -- her visual calendar showed to 2019. Her appointments don't go back to 2019.
A The -- there was no dot on that day, but it wouldn't show me anything for on 2019. It only went to 2020.
BY MR. WEIL:

Page 153

Q Okay. So a dot would indicate some sort of an appointment, even if you couldn't tell what it was?
A Correct.
Q Okay. There were dots in December 2019 or thereabouts, but just none on the 22nd?
A Yes.
Q Okay. I won't belabor this much longer. Does your family typically -- do you celebrate Christmas? Is that a festive time for your family? I know all families are different.
A Yes.
Q Okay. And do you typically celebrate it with -- I believe it was your -- you have adult children? Do you celebrate it with them, typically?
A Sometimes. My daughter's a nurse, so she has to work holidays occasionally. And my son is in Virginia, so we don't get together with him very often.
Q Okay. I believe you said that you and your husband had family around where you live?
A They live in Iowa. So it would be unusual for us to have a people over on a Sunday because most people work on Monday.
Q What town did you live in, during the events in this case?
A Onalaska.

Page 154

Q Onalaska. That's in Wisconsin?
A Yes.
Q Okay. I am going to show you now, what's been marked as Exhibit 19 in this case, Ms. Pisney. I think -- I'm sure you've reviewed it. This is the -- it's called a illness report, I believe. Do you have a copy of that handy?
A Yes.
MR. KNOTT: I'll get it.
Q Now, before we start talking about this particular document, Exhibit 19. You -- often, when you were called -- wait, let me back up a second. ACH produces a number of -- they're referred to as protocols or illness reports, it's a standardized form with various prompts for a guard to fill in information; is that right?
A Yes.
Q Are -- a lot of the calls that you get after hours. I understand nurses call you, but when a guard is calling you after hours or on the weekend, is it often in conjunction with them having filled out a form for a particular patient at the jail?
A Sometimes they do. I don't know if they do all of the time.
Q Okay. Referring you to Exhibit 19, which you

Page 155

have in front of you, is this a document that you saw before preparing for your deposition in this case?
A I did.
Q When did you see it?
A Just when it was given to me by the lawyers.
Q Okay. But contemporaneously with all this occurring, this is not something that you received, say, on the evening of December 22, 2019?
A No.
Q Okay. Was there -- when you were on call, was there a way to e-mail you or fax you medical documents?
A No.
Q Was that ever done?
A No.
Q Is it done now at the other ACH jails that you service and having -- having left Monroe County Jail?
A No.
Q Okay. When -- you testified this morning, that you recall receiving another call in the evening of the 22nd about Ms. Boyer experiencing chest pain; is that right?
A Yes.
Q Is it your practice to gather -- when you receive information like that, is it your practice to gather as much information from the guard who's calling

Page 156

you about the symptoms and the history of the patient who's experiencing chest pain?
A As best I can.
MR. KNOTT: (coughs) Excuse me.
Q Do you find the form -- the various prompts on Exhibit 19 to be helpful, in gathering relevant information for your assess of a patient with chest pain?
A I don't have this form with me usually, when I talk -- talk to the jail.
Q Sure. I understand. Maybe I can clear this up. In terms of the subject matters that this form prompts the guard to fill out, is that -- are these subject matters and the information that's gathered through this form, is this helpful for you to -- is this helpful information for you to assess a patient's complaint of chest pain?
A It would be if -- if it was all relayed to me.
Q Okay. When a guard calls you and says, I have a patient here who's complaining of chest pain, is it your practice to ask the guard whether they filled out this chest pain form?
A No.
Q Okay. You don't ask the guard, one way or the other, whether they filled out the chest pain form?

Page 157

A No. I do not.
Q Okay. Do you ask the guard to describe the information that they have available to them on the chest pain form?
A No. I typically would ask them some questions.
Q Is there any reason that you would not be given -- I believe, you said -- let's go through this. The first question asks the detainee history of -- then it goes into this -- I'll back up, I'm sorry. The first section is S, right?
A Yes.
Q Do you have an understanding of what S means in the context of this form?
A Subjective.
Q Subjective is what the patient is telling a care provider about the symptoms they're experiencing; is that right?
A Yes.
Q Is that important information for you to gather, in the event of someone who says they're experiencing chest pain?
A Yes.
Q Okay. Are the topics listed on S, on Exhibit 19, important pieces of information for you to

Page 158

understand for someone who's experiencing chest pain?
A Yes. They're -- they're typically things we'd like to know.
Q Okay. It's important for you to understand the history of the disease, whether you have elevated blood pressure, and whether you're on any medications; is that right?
A Yes.
Q It's important for you to know -- this information is important for you to be able to perform the differential diagnosis that we were discussing earlier; is that right?
A Yes.
MR. MCCAULEY: Form. Vague. Overly broad.
Q So it's important for the differential diagnosis to understand the history -- the detainee's medical history, to the extent they can give it, right?
A It is.
Q Okay. It's important -- so if a detainee gave a history of having a history of heart disease, that'd be very important for you to know, correct?
MR. KNOTT: Form.
A It would be.
Q Okay. Do you remember whether the -- do you remember -- do you have an independent recollection of

Page 159

what you were told by the guard, when you were called about this chest bank complaint, on the evening of Sunday the 22nd?
A The things I remember are that she was complaining of chest pain, that she was at rest, that there was no diaphoresis or sweating, and that she had some shortness of breath. I don't recall all of this information being relayed to me.
Q Do you have any reason to doubt -- do you have any recollection one way or another?
MR. KNOTT: She just answered that.
MR. WEIL: No.
A I said I don't recall them telling me this -- all this information.
Q Okay. Do you mean -- okay. Do you recall whether or not the guard who called you, related that Christine had told the guard that she had a history of congestive heart failure?
A I don't remember them telling me that. No.
Q Would you have asked the guard, did this patient who claims to be suffering from chest pain, did they tell you anything about their medical history? Is that question you would have asked?
A Since we had discussed the same patient multiple times during the day, I don't believe I

Page 160

would've. No. Because I --
Q You would not have -- okay. I'm sorry. Go ahead.
A I -- I understood that we did not know her medical history, that we did not have the specifics of her medical history, nor any of her medication that she normally took.
Q Okay. So you didn't say, has the -- you did not attempt or ask, whether this person had provided any additional medical history in the 24 hours since they'd arrived at the jail?
MR. KNOTT: Misstates her testimony.
A I -- I did not ask if there was new information about her medical history. No.
Q Okay. One of the first step in performing a differential day is to gather as much information as you can; is that right?
A That is correct.
Q So would you have attempted to gather any information that you could?
MR. KNOTT: Object. It's vague. Are we talking about this call? Are we talking about a generality? Vague -- vague time --
BY MR. WEIL:
Q When presented with a call from someone

Page 161

telling you that they had chest pain?
A As I said, that this person we had talked about multiple times during the day, and they had been -- they had told me that we did not know her full medical history. She was unable to give it, and we did not know her medication. So I did not ask again, have we found out anything new? Because it was Sunday, and we weren't able to get any new information.
Q That was a person who told you, that the night before Christine Boyer had come in, she was not able to give a complete medical; is that right?
A I don't know if it was the same person talking to me. No.
Q Well, was it Amber Fennigkoh who was talking to you this evening?
A No.
Q Okay. Evidently, Ms. Boyer was able to report that she was suffering from chest pain; is that right?
A That's why they called me. Yes.
Q Right. That's just -- that's something that somebody has to say, right? It's a symptom that they have to report?
A Correct.
Q Okay. Did you understand that Ms. Boyer had come in intoxicated the night before?

Page 162

A I don't remember them telling me that, either.
Q Okay. Did you see no reason to check and try to determine whether Ms. Boyer might know something else or have remembered something else about her medical history, given that she was experiencing chest pain?
A I had talked to them twice before with her high blood pressure, and they didn't relay any additional information at that time.
Q You didn't -- you told me, that you didn't ask for any additional information; is that right?
A I -- I rely on the officers to tell me the pertinent information.
Q Okay. You don't -- a guard -- the guards typically don't have medical degrees, right?
A No.
Q In gathering information, since you're not there, you have to rely on the guards to gather information for you, right?
A That is correct.
Q And often you have to direct the guard in gathering information because you do have medical training, whereas they do not; is that correct?
A ask them specific questions. Yes.
Q Okay. In performing a differential diagnosis -- the first step in performing a differential

Page 163

diagnosis, when someone presents with a symptom like chest pain, is to attempt to gather any information you can about their medical history; is that right?
MR. KNOTT: It's been asked and answered, at least five times.
A I did ask them questions --
Q Okay. Did you ask --
A -- in relation to her chest.
Q Okay. Would you have -- Ms. Boyer was able to relay the day before that she had cancer, right?
A That is one of the things she said. Yes.
Q And that was corroborated by the prescriptions that she had in her bag; is that right?
MR. KNOTT: Asked and answered. Argumentative. Misstates her testimony.
A The only thing that corroborated that was an order ondansetron from -- I don't know when, so...
Q Right. Ondansetron for someone who's experiencing chemotherapy, right?
MR. KNOTT: Asked and answered.
A That's what it said, but I don't know that -- that's a fact. I mean, people are given ondansetron for other reasons.
Q But what we talked about was that a prescription and bottle would have said, that was the

Page 164

reason she was being given ondansetron, right?
MR. KNOTT: Foundation. Speculation.
A Yeah. I would assume that was written on there because that was written on the MAR, but I don't know that for sure.
Q So all that would indicate to you, sitting here at 8:09 p.m., that Ms. Boyer did have some knowledge about her medical conditions, right?
A No.
Q Okay.
A I mean, other than -- no.
Q You recall that the prescription list that Ms. Boyer had, that we went over earlier, also had aspirin on it; is that right?
A Yes.
Q Is aspirin something that people with heart disease or high blood pressure take as a form of treatment?
MR. KNOTT: Asked and answered.
A It can be. But it can be taken for other things as well.
Q Okay.
A I don't -- that one I think was not a prescription.
Q Right. Aspirin is not prescribed, right --

Page 165

typically?
A Well, it can be.
Q Sure. But if someone's told to take aspirin by their doctor for high blood pressure or for a heart problem, they can just go and get aspirin and take it, right?
A They can. And people can take it just because they think it's good for them, too.
Q Right. One of the reasons that people might be taking aspirin, is because they've been told that it's important for high blood pressure or for a heart condition; is that right?
MR. KNOTT: Foundation. Speculation. Overly broad.
A That could be one of the reasons they're told to take it. They could also take it for headaches, body aches, all kinds of things.
Q So a possible indication of taking aspirin is that someone as a heart problem; is that right?
MR. KNOTT: Asked and answered.
A Along with all the other indications.
Q Okay. In performing the differential diagnosis that we talked earlier, that's one of the points of medical history that you would want to put as a possible indication that a person had a heart problem,

Page 166

right?
A Just because they were taking aspirin wouldn't necessarily tell me that they had a heart problem.
Q Right. It's a possibility, right?
A Along with a multitude of possibilities. Yes.
Q So when you were called by this person saying that Ms. Boyer is complaining of chest pain, your testimony is that you did not ask any questions about Ms. Boyer's any -- whether Ms. Boyer told the guard anything about her medical history; is that right?
MR. KNOTT: Misstates the testimony.
A Yeah. I -- I've said many times that I didn't, because I had talked to them multiple times about that same patient, that same day.
Q Okay. When Ms. Boyer reported the symptom of chest pain, did you ask the guard whether she had reported how long the chest pain was there? I'm looking at the first line here, the first star, under S. Did you ask the guard that?
A No. Usually, they call me when she complains of chest pain. So if she complained of chest pain, then they call me.
Q You have -- this is just not a question you ask, you don't ask the guard to report to you how long the person has said they had chest pain?

Page 167

A Usually, if someone has chest pain, they will report it. I -- and the -- and the jailer would call me with the complaint of chest pain.
Q Okay. So if I understand you correctly, you don't attempt to figure out how long they have chest pain because you assume that they would've reported it immediately?
A If they were having a heart attack and were having chest pain, then, yes. I would assume they'd report that immediately.
Q If they were having a heart attack and having chest pain, you assume that they would report it immediately?
A You said that chest pain is the only reason people -- only reason people have chest pain is because of a heart attack, and that that's their symptom, and that you should rule it out right away. So -- yes. I would assume that if someone had chest pain, they would report that right away.
Q Okay. When someone -- when a guard calls in with chest pain, you don't attempt to determine how long the person has had chest pain?
A No. I'm assuming that they call me when the person complains of the chest pain.
Q Right. And that person may have complained --

Page 168

it's possible that the person had the chest pain a while, then decided there must be a problem, and told the guard after they'd been experiencing it for a while; is that right?
A I would -- I would assume that that wouldn't be hours at a time, only minutes.
Q Is it a possibility you want to exclude that the person had been experiencing chest pain for some time, and had decided to report it?
A I think I've answered that multiple times, too.
Q I don't -- can you just answer the question, please?
A When they call me with the complaint of chest pain, I assume that they've just complained to the officer of the chest pain, and that's why I'm being called. So I don't assume they've been having chest pain all day, and then just suddenly decided, you know what, maybe I'll report this now. So -- no. I assume that's a pretty recent complaint.
Q Okay. So do you think this how long has it been there is a completely superfluous question on this chest pain chart?
MR. MCCAULEY: Form.
A For other types of pain, I would think that

Page 169

would be pertinent. But for chest pain, that's usually something that people would report right away.
Q Okay. So if you were editing this chest pain chart, you would strike this line, "How long has it been there"?
MR. KNOTT: Form. Hypothetical.
A These are the typical questions you ask anybody with any complaints of pain. But that's --
Q Well, any complaints of -- go ahead. I'm sorry.
A Any complaints of pain, it's a pain -- pain questionnaire, basically.
Q Well, this isn't just a questionnaire about how are you feeling. This is a questionnaire that's designed to help a practitioner detect whether someone's having a heart attack; is that right?
A That's what it's meant to do. But they're -- I mean, these are questions I would ask someone if they had a pain in their toe. I mean, it's not -- chest pain is usually something that people would report right away.
Q If you were editing --
A I'm assuming that --
Q Go ahead.
A I'm assuming that when they complain of the

Page 170

chest pain, it's a recent development, and the officer's calling me with that recent development of chest pain.

Q Okay. So if you were editing this chest pain chart, you would strike that question as irrelevant and not helpful; is that right?

MR. KNOTT: She's answered that question

A Protocols -- or these forms are -- they're not individualized. So it depends on the individual. It depends on what I want to get at, but that's not something that I ask them.

Q My question was, if you were editing this form to help a practitioner detect chest pain -- detect heart attack as a result of chest pain, is, "How long has the chest pain been there," a line that you would delete because it's just not helpful in assessing whether someone is suffering from a heart attack? I would like you to answer that question.

MR. KNOTT: It's been asked and answered.

MR. WEIL: No. It has not been answered, Doug.

MR. KNOTT: It's been asked and --

MR. WEIL: Doug, it has not been answered.

MR. KNOTT: It's been asked and answered, three times.

MR. WEIL: No. It has not.

Page 171

MR. KNOTT: Don't interrupt me. It's been asked and answered -- it's been asked and answered.

MR. WEIL: Are you going to instruct the witness not to answer this question. Because otherwise, I'd just like to get an answer from her?

MR. KNOTT: She's answered it three times. You get one more shot at it, then we're moving on.

A I don't write these forms. So I wouldn't edit it.

BY MR. WEIL:

Q If -- the question is, if you were editing it, ma'am. If you were editing this form, is this a line that you would strike from it?

MR. KNOTT: Okay. You've asked it five times. This is it. Steve, we're not doing this all day.

A The -- So I talked to this -- about this person multiple times during the day. None of those times did she complain of chest pain previously, even though on this form she says that -- or they say, that she had it on and off all day. She did not complain to anyone about chest pain on and off all day. It is not one of the questions I asked. So I didn't feel it pertinent and I did not ask about it.

Q My question is about you editing this form. Okay? If you had control of this form, and what you think is useful in determining and helping you conduct a differential diagnosis of chest pain, would you strike this line from the form because it's not useful?

Page 172

MR. KNOTT: Ms. Pisney, you may answer again, or you may stand by your prior answers

A In this case, I didn't find it useful.

Q Ms. Pisney, I'm asking you about what you would do if you were editing this form. Would you strike it?

A That's a hypothetical question and I -- that's a hypothetical question and I don't feel I can answer it.

Q It is a hypothetical question. Why can't you answer it? If you were controlling -- if you were editing this form, I'm asking what you would do, if you were editing a chest pain form to help a practitioner --

MR. WEIL: Doug, if we're going to do this --

MR. KNOTT: This has --

MR. WEIL: -- we're going to mark the transcript and I'll just move to compel. Okay? So it's your choice.

MR. KNOTT: This has reached the point -- this has reached the point of harassment. You're --

MR. WEIL: Okay.

MR. KNOTT: You -- this is well past the point of harassment, so I'll protect her. I'm not going to let you keep brow beating her and harassing the witness over --

Page 173

MR. WEIL: Okay.

MR. KNOTT: And what pertinence does it have, if she was -- all -- she was editing a security document?

MR. WEIL: Doug, don't coach the witness, A. B, this isn't a security document, right? This is created by ACH.

MR. KNOTT: Yeah. I don't know.

MR. WEIL: Okay. Well, listen. Doug, I'm going to ask the question, and then you can make your record --

MR. KNOTT: Get to it.

MR. WEIL: -- and we'll mark this part of the transcript. Okay?

BY MR. WEIL:

Q Ms. Pisney, we've been talking about this line. How long has the chest pain been there, right?

A Correct.

Q Your testimony is, that it's not your practice to inquire into that matter because you assume that any chest pain has been reported immediately; is that right?

A Or within a short amount of time. Correct.

Page 174

Q Okay. And so if you were editing this chest pain form, you would -- would you strike that line from the chest pain form as useless, in performing a differential diagnosis?

MR. KNOTT: Object to the form of the question. Asked and answer. Ms. Pisney, you may answer again or you may stand by your prior responses.

A I didn't find it pertinent, at the time.

BY MR. WEIL:

Q Okay. And my --

A My -- so I can --

Q Okay.

A As -- in my professional judgment, I can decide if something is pertinent or not, and ask that question. I didn't find it pertinent, so I did not ask that question. There are many questions I could ask, but I did not find it pertinent, at this time, to ask that question.

Q Okay. And I believe that you said when Ms. Boyer had reported high blood pressure earlier, and she had prompted the guard to take her blood pressure, you also didn't ask whether she had any other symptoms; is that right? That was your testimony, right?

A No other symptoms were reported to me.

Page 175

Q And you didn't ask if she had any other symptoms, did you?

A Lord.

MR. KNOTT: Object to the extent, it misstates prior testimony.

A I didn't recall.

Q Okay. If those symptoms had been reported to you before, you would have learned that around 3:00 p.m., Ms. Boyer had -- felt like she could not breathe, and had a blood pressure of 177 over something very high, right?

A Yes.

Q And you agree that shortness of breath followed by chest pain is a sign of a heart attack; is that right?

A That was five hours previous. So I wouldn't have considered those to be in the same realm, at all.

Q Okay.

A I -- I didn't -- they were not associated.

Q Do you agree that the symptoms of chest pain can go on and off for hours?

MR. KNOTT: Asked and answered.

A Yeah. We did talk about that previously. It can be minutes or hours.

Q Right. Right.

Page 176

A Did not specifically complain of chest pain at that time, though.

Q Okay. She just complained that she could not breathe?

MR. KNOTT: Asked and answered.

A Her oxygen saturation was normal.

Q Did you take an oxygen saturation measurement in the afternoon --

A I --

Q -- when she said she could not breathe?

A I believe they did, but I'm -- can't be certain.

Q Did you -- do you have any -- did you see any document preparing for this deposition, indicating in the afternoon when there was a call about Ms. Boyer having extremely high blood pressure and not being able to breathe, that any sort of oxygen saturation test was done?

A I -- I thought there was, but perhaps they didn't.

Q Okay.

A I don't know. Did she ever receive her -- her inhaler?

Q Do you -- the next line is, "What caused pain," do you see that?

Page 177

A Yes.

Q Is that a question you'd want to know the answer to?

A I don't think that the patient would be able to answer that.

Q Okay. Well, a patient who might say something like, well, I bumped into something and I'm having chest pain after having bumped into something. That would help you exclude the possibility or reduce the likelihood, that this -- the pain that they were experiencing was caused by a heart attack; is that right?

A I believe that the jailer would've relayed that information to me.

Q So you wouldn't ask that information?

A God. If the jailer called me and said, this person fell into a chair and now they're having chest pain --

Q Okay.

A I -- they tell me those things.

Q Would -- the next line is, "Any similar symptoms before," do you see that?

A Yes.

Q Is that a question that you would want to ask the patient who's coming to you with chest pain?

Page 178

A Yes.
Q Okay. And is that a question that you would ask the guard, to relay any information about?
A I -- I didn't specifically ask that question.
Q You didn't ask that question, either?
A I did not.
Q Okay. "Does the pain come and go," do you see that question? The last star under S.
A I do.
Q Is that an important question to ask a person, who's complaining of chest pain?
A It could be.
Q Okay. Is that a question that you would've asked the guard to relay any information about to you, if you'd gotten it?
A I don't have this questionnaire memorized. I asked what I feel is pertinent at the time, in my judgment, and in knowing the -- the information about the patient.
Q What information do you attempt --
A Every --
Q Okay. Go. I'm sorry. Go ahead.
A Every patient is different. I had talked to them multiple times about this patient, so I felt that I had an understanding of what we knew about the patient.

Page 179

They had called me before and told me she had chest -- or she had high blood pressure. We were treating her high blood pressure, that was improving. They called me many, many hours later and said she'd had a complaint of chest pain. We talked about that. Her blood pressure was still a little elevated, so I thought perhaps the blood pressure could be leading to some of the chest pain. We gave her aspirin because I didn't think that could hurt anything. And then I asked them to recheck her blood pressure in half an hour, and call me if it was elevated, and also to let me know if she continued to have chest pain. They never called me back, so I assumed that she -- her blood pressure was fine, her chest pain resolved, and she was resting comfortably.
Q When you say, "They called me with chest pain," I wrote down you said, "We talked about that"; is that right?
A We did. I asked --
Q Okay.
A -- were there any other symptoms associated with the chest pain? Was the chest pain at rest? Was she diaphoretic? Did she have shortness of breath? Those are --
Q Did you --
A -- the typical questions --

Page 180

Q Okay.
A -- I would ask.
MR. KNOTT: Don't interrupt.
Q Okay. You said diaphoretic?
A Yes.
Q And shortness of breath?
A Yes.
Q You didn't attempt to gather any information about her medical history?
A No.
Q You didn't attempt to gather any information about whether she'd been experiencing chest pain throughout the day?
MR. KNOTT: Asked and answered.
A I did not at that time. No.
Q You didn't attempt to gather any information about whether the pain came and went; is that right?
MR. KNOTT: Asked and answered -- asked and answered.
A I did not.
Q Did you ask her -- did you ask the guard to inform you what the chest pain felt like?
A I may have asked them that.
Q Okay. And would you expect the guard to have reported that it was, achy, stabbing, and "I'm not

Page 181

right"?
A I do not remember them ever saying, that she said, I'm not right.
Q Given that that's written down on the form, is there any reason you think that the guard would not tell you that?
MR. KNOTT: She just -- that's -- she just answered that.
MR. WEIL: No. She didn't.
A I don't --
MR. KNOTT: Yes. She did. She just -- she told you what her recollection is and you keep asking is there any reason when she just told you the reason.
MR. WEIL: Yeah. I know.
BY MR. WEIL:
Q I'm just asking if there's -- you have any reason to think that they didn't also tell you, "I'm not right," as -- since she reported that symptom.
MR. KNOTT: She just answered it.
A I don't recall them telling me that.
Q Okay. Do you -- would you have asked about whether she had nausea or vomiting?
A I would not. That's not something I typically think about as a -- as a symptom of chest pain. But, as

Page 182

we've gone through the American Heart Association's typical symptoms, that's what they did give. I did not ask about nausea and vomiting.

Q Okay. And you didn't ask whether she was dizzy?

A No.

Q Okay. And you said that you asked whether she was short of breath, right?

A Yes.

Q Okay. And she reported that she was -- that's what the guard reported?

A As some shortness of breath.

Q Okay. So she had some shortness of breath, along with chest pain?

A Yes.

Q Did you ask the guard whether Ms. Boyer reported being on any medications at all?

A No. Because I was under the understanding that we did not know her medications.

Q And that's based on a conversation that Ms. Boyer had on intake that --

A Earlier that day.

Q Well, the day before, right?

A It was my conversation, earlier that same day.

Q You understood that Ms. Boyer had been brought

Page 183

in the night before?

A Yes. I -- I don't know that I knew that in particular, but I can't -- it's not in my recollection, but --

Q Okay.

A -- now I know she had been brought in the night before.

Q However long the time that elapsed, would you want to exclude the possibility that she might have more information about her medical condition or her medical history, in the time that had elapsed since she'd been brought in?

A I would've thought that if she was on other medications for her blood pressure, when she -- they called to tell me she had high blood pressure, they would've told me that.

Q My question was different, Ms. Pisney. I'm asking, if you would've wanted to exclude the possibility that she might have recalled more about her medical condition, given that she was complaining about chest pain? Is that something you would've wanted to make sure you could explore any information that you could gather about that?

MR. KNOTT: Form.

A I had talked to them multiple times during the

Page 184

day and no new information was given to me.

Q And I think, as we've talked about today, on all those times, you told me that you did not ask whether she had any other symptoms beside high blood pressure, right?

MR. KNOTT: Object. Misstates the testimony.

A The -- the officers typically will tell me the symptoms that the patients are complaining of.

Q So in other words, they would have told you before that she was complaining that she couldn't breathe before, right?

MR. KNOTT: Foundation. Speculation. All right. Yeah.

A I -- my testimony isn't going to change. I just -- I just told you what I recalled.

Q Yeah. Okay. If the officers typically tell you the symptoms that someone's complaining of, they typically would've told you about all the symptoms that are listed here under S; is that right?

MR. KNOTT: Well, that's -- that's speculation. Foundation. And she's testified to her memory of the calls. I -- this -- this constant asking what the officers would do after she tells you her memory of it is I think --

MR. WEIL: Doug, she just described her --

Page 185

what --

MR. KNOTT: I think is not --

MR. WEIL: -- officers typically do. I'm just off -- asking what officers typically do. Okay? So if someone --

A They typically do not read this verbatim to me, and I've never had an officer give me this much detail about a patient, ever.

BY MR. WEIL:

Q The line under, "Location of chest" --

MR. KNOTT: It's in exhibit -- just -- I just need, when she said this, it's referencing Exhibit 19.

MR. WEIL: Yeah.

MR. KNOTT: Right?

THE WITNESS: Yes. Correct.

MR. KNOTT: Yeah.

BY MR. WEIL:

Q So regardless of whether it's read verbatim, what about -- would you expect that officers would typically read in substance the conditions that someone -- that a patient had complained about?

A They tell me that she's having chest pain. They answer any questions that I have. They typically tell me their vital signs. If something that I ask

hasn't been answered by the patient, then sometimes they will go back to the patient and ask them that question.

Q Okay.

A But --

Q So I've -- down here under neck -- pain in neck, shoulder, arm, would you ask -- would it be your practice to ask the guard, to tell you what the patient has told you about what the location of the pain is -- the chest pain?

A I do typically ask about where they're -- where in the chest they're having pain.

Q Okay. And this says, "Underneath the left shoulder," do you see that?

A Yes. I do.

Q And that's a sign that is consistent with a heart attack; is that right?

A It was on the AHA sheets that you showed me.

Q And you agreed that -- you agreed with -- that it was consistent with heart attack, right?

A It can be.

Q Okay. It makes it more likely; is that right?

A Also makes shoulder pain more likely, so...

Q Okay. And given -- in the differential diagnosis, you would -- if you learned that someone has chest pain and they have pain underneath their left

shoulder, you would want to exclude, absolutely, the possibility that they have a heart attack; is that right?

MR. KNOTT: Foundation. Incomplete hypothetical. Vague. Overly broad.

A This -- this lady was 41 years old, which is typically not a postmenopausal woman. I didn't know that she had any history of heart disease. Typically, a premenopausal woman is not likely to have a heart attack. Many times in the jail, they're complaining of chest pain, shortness of breath, when they're anxious. This is the first time she's ever been in the jail. Anxiety was a more likely diagnosis than cardiac, in my judgment.

Q So anxiety would be a relatively benign diagnosis of a chest pain condition, right?

A It -- yes.

Q Another diagnosis -- another possible cause of chest pain, particularly pain under the left shoulder, is heart attack; is that right?

MR. KNOTT: It's been asked and answered, many times.

A In a 41-year-old woman with no known history of heart disease, as far as I knew, it's unlikely to be cardiac in nature.

Q Okay. Is --

A In my judgment --

Q Go ahead.

A In my medical judgment, it was not high on the differential, that this was cardiac.

Q By high on the differential, you mean the list that you make in your mind of possible causes of the symptoms that's being reported?

A The likelihood of those being the cause.

Q So even a lower likelihood cause -- I'm sorry. I didn't mean to interrupt you. Go ahead, Ms. Pisney.

A So in my judgment, in my experience in treating patients in the jail -- in my professional judgment, I didn't feel that cardiac was high on the list of differential. We had been treating her blood pressure and having good responses to the medications. Clonidine is also helpful in use -- in helping with anxiety, and withdrawal, and her blood pressure was improving. It was up a little bit when they called me with the chest pain, so that's why I wanted them to check again in a half an hour, and also to let me know if she'd had any continued chest pain. From the observations that the officers made after that time, they rechecked her blood pressure. It was not elevated. She did not continue to complain of chest pain, and she

was resting comfortably throughout the night.

Q When you say it's not high on your list, in your judgment, you're not free to just knock potentially deadly causes of a symptom off your list, right? You have -- in the differential diagnosis, you must rule out or treat a deadly symptom that could kill a person within hours; is that right? A deadly cause --

MR. KNOTT: Foundation --

Q -- of a symptom that could kill a person within hours?

MR. KNOTT: Foundation. Vague. Overly broad.

A Yeah. That's -- I -- there's no, you have to do this, you have to do this, you have to do this. There's there's none of that. People complain of headaches and it can be an aneurysm, but you don't get an MRI on everybody that has a headache.

Q If someone's complaining of chest pain, they're nauseous or -- and they're complaining of chest pain under the left shoulder, your judgment is that heart attack does not have to go very high on the list of potential causes of those symptoms?

A There's a whole list of things that you take into -- into making a diagnosis. Again, I talk about this 20-year-old male that comes to you with chest pain and left shoulder pain. He's more likely to have a

Page 190

rotator cuff tear than he is to be having a heart attack. So a 41-year-old, premenopausal woman, with no heart history, as far as I know, who's in the jail, not happy to be in jail, anxious about being in jail, is more likely to be having an anxiety attack than to be having a heart attack. In my professional judgment, I didn't feel that she was having a cardiac event, and that anything else needed to be done besides what I was doing. I was treating her. I was monitoring her, and she did not have any further symptoms.

Q What question did I ask you that you were answering?

A You said that -- you asked me if I was able to take chest pain off the list of the differential diagnosis. And I was telling you how I was using my professional judgment to decide what to do in the plan of care for this patient.

MR. KNOTT: Counsel.

MR. WEIL: So --

MR. KNOTT: I could use a comfort break soon. And when you're asking her what question you asked her, I think we're at a point where maybe that would be good.

MR. WEIL: Well, yeah. We can take a break. That's fine. Come back in five minutes, 3:37?

Page 191

MR. KNOTT: Yep.

MR. WEIL: Okay.

COURT REPORTER: We're off the record. The time is 3:32 p.m.

(OFF THE RECORD)

COURT REPORTER: We are back on the record for the deposition of Lisa Pisney being conducted by video conference. My name is Sydney Little. Today is March 3, 2022. And the time is 3:50 p.m.

BY MR. WEIL:

Q Ms. Pisney, when we got off the record, before we took a break, I -- really quickly, the symptoms that you talked about were -- you asked the guard to report whether Ms. Boyer had experienced any similar symptoms before; is that right?

A No. I did not.

Q Okay. You did not. And you didn't ask her whether -- about the -- whether the pain comes and goes, right?

A Correct.

Q Did you ask whether Ms. Boyer was experiencing nausea or vomiting?

A I did not.

Q Okay. Did you ask whether Ms. Boyer was experiencing dizziness?

Page 192

A I did not.

Q Did you ask -- I believe you did ask, where Ms. Boyer was experiencing the pain -- where on her body?

A Correct.

Q Okay. And --

A That's my memory, anyway.

Q Okay. And what -- it says on this form, on Exhibit 19, "Underneath left shoulder," are you looking at 19?

A Yes.

Q Okay. Is that consistent with the recollection about what you were told in response to that question?

A I don't remember specifically.

Q Okay. Is there any reason to think -- given that that's what's written on this form, is there any reason to think you would've been told something different?

A No.

Q Okay. The next prompt is that, "Have detainee pinpoint area of pain." Would you have asked the guard to have Ms. Boyer pinpoint the area of pain?

A No.

Q Okay. And you asked about shortness of

Page 193

breath, I believe you said, right?

A Correct.

Q So of all the questions I have on this first page, under S and O, the two questions that you recall asking -- or that you believe you asked are, "Is the pain in the neck, shoulder or arm," and, "Is there any shortness of breath"; is that right?

A I asked -- I likely asked whether she was having any shortness of breath, any diaphoresis, any other symptoms besides the chest pain.

Q Any other symptoms beside the chest pain?

A Correct.

Q Okay. And so, would you have asked about dizziness then?

A I didn't specifically ask that but --

Q Okay.

A -- I did ask for any other symptoms, and I don't remember them relaying any other symptoms.

Q Okay. Given that dizziness is written on here, would you expect that the -- if you'd asked for any other symptoms, that the guard would have told you that Ms. Boyer was also feel dizzy?

A I --

MR. KNOTT: Form of the -- form of the question. Foundation. Speculation.

Page 194

A I don't remember them telling me that.
Q Any reason to think that they would not have told you that, if you asked whether there are any additional symptoms?
MR. KNOTT: She just answered that question, based on her recollection. So I think that's an improper question. Asked and answered.
BY MR. WEIL:
Q Can you answer my question, please, Ms. Pisney?
A I just don't remember them ever telling me that.
Q Okay. But my question is, given that it's on this form, do you have any reason to think that they wouldn't have told you that, if you asked for any additional symptoms?
A I --
MR. KNOTT: She can only testify -- foundation. Speculation. Asked and answered.
Q Okay. If you ask for any additional --
A I can't --
Q Okay, go ahead. I'm sorry.
A I can't -- I can't tell you why they wouldn't have told me or why they would have told me. I just asked for any other symptoms, and I don't remember them

Page 195

telling me that.
Q Okay. Another symptom listed on this form is, nausea or vomiting, do you see that?
A Correct.
Q If you asked for any other symptoms, would you expect the guards to have told you that she'd answered yes, to the question of nausea or vomiting?
A It would be another --
MR. KNOTT: Same objection -- same objections.
A Yeah. It would be another symptom but I don't remember them telling me that.
Q Any reason to think that they would not have told you that she had answered yes to the question, nausea or vomiting, if you asked whether she was experiencing any other symptoms?
MR. KNOTT: Same objections. Asked and answered.
A I have no reason why they would not tell me or would tell me. I -- I asked for other symptoms. I always ask for other symptoms.
Q Okay. The other thing that it says on here above dull, aching or sharp pressure is, "I'm not right," do you see that?
A Yes.
Q And that's in quotes. Would you agree it

Page 196

appears that the guard is recounting something that Ms. Boyer said?
A That appears to be so on the sheet. But I don't remember them telling me her -- describing that to me.
Q Okay. If you asked the guards to describe any other symptoms, given that, "I'm not right," is written on the sheet. Do you have any reason to think that the guard would not tell you that Ms. Boyer reported, "I'm not right"?
MR. KNOTT: Same objections. Asked and answered.
A I can only tell you what I remember and I don't remember that being recalled.
Q Okay. But you have no reason to think it wasn't told to you, right?
MR. KNOTT: Same objections. She's already testified. Asked and answered.
A They -- I don't know what that -- I just don't recall them ever saying that to me.
Q Okay. And you never asked whether she'd experienced similar symptoms before?
A No.
MR. KNOTT: Asked and answered.
Q Okay. When we went -- before we went on

Page 197

break, I believe you said that -- something to the effect of, and I -- correct me if I'm wrong. People who are in jail often experience anxiety, and it was your judgment that Ms. Boyer was likely experiencing anxiety; is that right?
A That it was -- I thought it was more likely than -- a more likely explanation for her symptoms than chest -- than cardiac.
Q Okay. So it's more likely she was experiencing anxiety than a heart attack. Is that -- that was your assessment, in your judgment?
A With -- with the information I had at the time, yes.
Q And in performing a differential diagnosis, anxiety would be low on the terms of when you're listing causes and trying to make sure that you rule out or treat causes, anxiety would be low on that list, right?
A It would be a more benign cause.
Q Okay. And a more -- the -- not withstanding your judgment, that this was caused -- that the symptoms that we've gone over -- or that were reported to you were caused by anxiety, another potential cause of those symptoms was heart attack; is that correct?
A That's a possible diagnosis.
Q And it's critical when conducting a

Page 198

differential diagnosis, that you rule out and treat a much more dangerous possible cause of those symptoms, such as heart attack; is that right?

MR. KNOTT: It's covered, easily for an hour this morning. Asked and answered. Please don't retread that ground.

A The -- you have to take everything into consideration, when making a judgment about what you think could potentially be the cause. And in taking everything together, I thought the more likely diagnosis was anxiety than cardiac.

BY MR. WEIL:

Q The more serious and deadly potential cause of the condition was heart attack, though. Given the symptoms that we've just gone over today, right? They -- just going over that you think that you -- were reported to you on this chest pain call, on the evening of Sunday, the 22nd; is that right?

MR. KNOTT: Object to the form of the question.

A Knowing nothing else besides the symptoms that could -- that would be, of course, more serious. But I -- you have to take everything into consideration when you make a diagnosis and a judgment.

Q The differential diagnosis requires you to

Page 199

rule out more serious symptoms, though, right? Most --

MR. KNOTT: Been asked and --

Q More serious potential causes.

MR. KNOTT: Asked and answered, multiple times. It's argumentative.

A It's not a cookbook. You can't just say, check, check, check. There's -- that's not how it's done.

Q Okay. So you're presented with someone -- and we've gone through this list of what you believe you recall being told. And so we talked about differential diagnosis in the abstract this morning. Now I'm trying to deal with the information that you were provided with. Okay? What you were provided with, according to your memory, is that you were told that this person had chest pain, correct?

A Yes.

Q And that the chest pain was underneath the left shoulder, correct?

A Yes.

Q And that they had some shortness of breath --

A Yes.

Q -- correct? Given those three conditions that you recall being told, one possible cause of those conditions, if I understand you correctly, is that

Page 200

Ms. Boyer was simply anxious; is that right?

A Correct.

Q And another possible cause of those three symptoms is that Ms. Boyer was experiencing a heart attack; is that correct?

A It's a possible cause.

Q And it would be -- and a heart attack is exponentially more serious than anxiety, when you're performing differential diagnosis; is that right?

MR. KNOTT: Asked and answered, multiple times. Argumentative.

A It is a more serious diagnosis but I thought it was less likely --

Q Okay.

A -- because of her age, and sex, and other diagnoses that I was not aware of.

Q Another diagnosis, meaning that she had cancer, right?

A Yeah. Cancer doesn't necessarily make you at a higher risk of heart disease.

Q Okay. Given the -- you believed it was less likely, given that heart attack was a possible cause of those symptoms, it's important to put that at the top of the differential diagnosis list, in order to rule it out before it's able to kill the patient; is that right?

Page 201

MR. KNOTT: Asked and answered, at least ten times.

A In this case, I didn't feel that it was high on the list of the differential. Things were more likely to be causing her chest pain than cardiac cause, because her age, her sex.

Q Did you feel --

A I just thought it was unlikely.

Q Okay. So you chose not to rule out cardiac because you thought other things were more likely?

A I chose not to go further down the cardiac path because I thought other diagnoses were more likely. Yes.

Q And it's your testimony, that that's an acceptable practice when performing the differential diagnosis?

A In the situation that I was in, and the information I had. Yes.

Q Your -- turning to the second page of Exhibit 19, so it's the back page. Your prescription was to give Ms. Boyer 81 milligrams of aspirin -- your instruction was to give her 81 milligrams of aspirin; is that right?

A Yes.

Q Okay. And then to call -- to check her vital

Page 202

signs and call back in half an hour; is that right?
A Yes. If it was elevated, and she had any more chest pain.
Q Okay. And the one vital sign that I see changing is that her -- I believe her diastolic pressure moved from 102 to 92; is that right?
A Yes.
Q There is no other change in her vital signs; is that correct?
A That is correct.
Q Okay. And did you tell the guard what vital signs would be abnormal in these circumstances, and what would not be?
A They know the normal vital signs.
Q Okay. And the other instruction you gave, is to call back if she was still complaining of chest pain?
A Yes.
Q Given that you had concluded that Ms. Boyer's chest pain was likely caused by anxiety, why would it matter to you if she was still complaining of chest pain a half an hour later?
A That either she was anxious or she was having -- it could be more cardiac related.
Q Okay. So if she was complaining of chest pain an hour later --

Page 203

A If it didn't go away --
Q -- it could be cardiac?
A If the chest pain didn't go away, it would be higher risk that there could be something cardiac going on, that's why I wanted to know. I was following up and making sure that she improved.
Q What sort of -- do you give any medication for anxiety, in your practice?
A Sometimes. I had given her clonidine previously, that also helped with her blood pressure and with anxiety.
Q Okay. Does aspirin help with anxiety?
A No.
Q Okay. If you thought she had anxiety, why didn't you prescribe something for it?
A I'd given her clonidine earlier, and I wasn't sure I wanted to give more clonidine. And the officer asked me about giving her aspirin, and I didn't think that it would hurt anything to give her some aspirin.
Q So you didn't -- it was not your idea to give aspirin, it was the guard's?
A They mentioned it to me. It's not something I would typically do.
Q What had been your planned -- having gone through the sheet, what had been your planned course of

Page 204

treatment, before the guards suggested that you provide aspirin?
A I was still thinking about it.
Q Yeah. We noted a while ago that -- when we were reviewing the symptoms of heart attack, that chest pain pay -- a heart attack may be occurring, but chest pain comes and goes; is that right?
A That's correct.
Q So the fact that Ms. Boyer might not have chest pain one half hour after you provided her with aspirin, would not exclude the possibility that she -- that the chest pain she was experiencing was caused by heart attack; is that right?
A I would expect the officers to call me, if she had chest pain at any other time.
Q Okay. The question I had was, the fact that Ms. Boyer was not -- would -- might not be experiencing chest pain one half hour after you gave -- ordered this 81 milligrams of aspirin, would not exclude the possibility that she had a heart attack; is that right?
A No. But they would have called me, if she had chest pain at any time.
Q Did you leave an instruction to call, if Ms. Boyer had chest pain any other time?
A I said if she had any further chest pain to

Page 205

call.
Q This is a -- okay. And if chest pain goes in and out over the course of hours, why do you think that that would exclude the possibility of heart attack?
A She never complained of chest pain again. She complained once, and that was all.
Q Okay. If chest pain goes in and out over the course of hours, why do you think that that would -- why does a complaint later of chest pain -- or checking about chest pain, exclude the possibility of heart attack?
A There was only one complaint of chest pain, so it -- it wasn't going in and out, as far as I knew.
Q Okay. And would the question of whether it was going in and out be important when you're deciding that a further complaint of chest pain is going to be enough to indicate to you -- just to rule out heart pain -- or heart attack later on?
A If she continued to complain of chest pain, then that would have led to more discussion.
Q Do you have any idea where Ms. Boyer was housed in the jail?
A In the jail -- I believe she was in the booking area.
Q Okay. If Ms. Boyer had difficulty describing

Page 206

her symptoms or her medical history to someone, would there -- would you be concerned that she might not be able to describe a history of chest pain, over the course of the day?

A She had complained of her blood pressure being elevated previously, she'd asked for her blood pressure to be checked, she complained about the shortness of breath that you talked about, she complained about the chest pain. So she didn't seem to have any problem telling the officers when she had a complaint.

Q Okay. And not withstanding that you assumed that she would be unable to account -- recount any medical history about chest pain; is that right?

A When I was called earlier in the day, there was no information, we did not have her medical information, and I was not given any information that that had changed.

Q Do you really think it's likely that Shasta Parker, who placed this call and filled out this form, called you that Ms. -- told you that Ms. Boyer was experiencing chest pain, but did not bother to tell you that she had reported to Shasta that she had congestive heart failure?

MR. KNOTT: Object to the form of the question. It's argumentative. Lacks foundation.

Page 207

Calls for speculation.

A I just -- I never remember hearing anything about a heart history on this patient.

BY MR. WEIL:

Q Given that it's written down here, do you think it's likely that Shasta -- more likely than not, that Shasta Parker, who filled out this form, called you and reported that among -- in addition to having chest pain, Ms. Boyer had reported a history of congestive heart failure?

MR. KNOTT: Asked and answered.

A Again, I don't recall being told that.

Q I'm asking, do you think it's more likely than not?

MR. KNOTT: Calls for speculation. Foundation. Asked and answered.

A I -- there were other things on this form that I don't recall being told as well, so it's possible that that wasn't relayed to me.

Q Possible it was?

MR. KNOTT: Same -- same objections.

A I don't recall.

Q Okay. Did you review a -- an e-mail where there's a conversation reported between you and Travis Schamber?

Page 208

A No. I don't remember that.

Q Okay. We talked about that briefly this morning, that you talked with Travis Schamber before -- or after this incident with Ms. Boyer?

A Yes.

Q Did -- did -- do you recall -- I believe you said you don't recall Travis Schamber looking at any documents or going over any documents with Dr. Schamber, as he was recounting the history of what happened -- or you were recounting the history of what happened?

A I think eventually he got the documents, but I don't know if he had them at the time we had our conversation.

Q Okay. You don't recall him referring to any documents about Ms. Boyer's medical history, or medical condition, or anything like that?

A I don't know if he -- when we discussed, if he'd had information about the -- her hospitalization afterwards. That's possible.

Q Do you recall whether Ms. Fennigkoh was on that call as well?

A No. We did not talk to them together, as far as I know.

Q Okay. So it was just you and Travis Schamber on that call?

Page 209

A I believe so.

Q Okay. Do you recall Travis Schamber saying that -- what had happened, that everything was kosher, regarding your care of Ms. Boyer?

A He reassured me that he didn't think I did anything wrong, that there was nothing wrong with the care I gave the patient.

Q Did Travis Schamber ask you whether you attempted to perform a differential diagnosis of Ms. Boyer's chest pain?

A No. We talked about the calls that were made to me, the information that was relayed to me, the decisions I made with that information, and he didn't find that there was anything wrong with that.

Q And were you looking at any documents, when you told him what information was relayed to you?

A No. It was just my memory.

Q Okay.

A But it was clear memory, since it was recent.

Q This is -- I'm showing you now what's been marked as Exhibit -- I'm sorry. I apologize, I'm going to have to get the -- the exhibit number. I'm sorry, hold on. Okay. So, Ms. Pisney, I'm showing you what's been marked as Exhibit 24. It's a December 24, 2019 e-mail from Amber Fennigkoh to Stan Hendrickson and Ryan

Page 210

Hallman (phonetic), do you see that document?
A Yes.
Q Is this the document -- is this a document you reviewed in preparation for your deposition?
A I'm not sure if that was included, but I -- I think I've seen it before.
Q Can you read it real quick to refresh yourself on it?
MR. KNOTT: Is it -- can you read it?
THE WITNESS: Uh-huh.
MR. KNOTT: All right.
A Okay. I've read it.
BY MR. WEIL:
Q Okay. Does this -- does Exhibit 24 refresh your recollection at all about the substance of the call with Dr. Schamber, or who participated in that call?
A I still think that I just spoke with -- by myself to Dr. Schamber, but I'm sure Amber had spoken with him as well, at maybe a different time.
Q Okay. In this e-mail, it appears that Ms. Fennigkoh is saying that she reviewed -- wait, okay. I'm sorry. Do you recall Dr. Schamber saying to you that everything was kosher, in terms of the care that was provided to Ms. Boyer?
A I don't think that he probably used that

Page 211

particular term. But like I said, he told me that he didn't think I had done anything wrong.
Q Okay. And you recounted to him, I'm assuming in much shorter form and substance, what you recounted to me today? In terms of what information you got, what information you requested about Ms. Boyer over the -- over the calls that you had?
A I'm sure, maybe in better detail then, because it was just right afterwards.
Q Okay. Do you recall Dr. Schamber telling you -- I'm looking at the last line here, "Dr. Schamber also told Lisa he wouldn't be surprised if she didn't make it," do you see that?
A I do. I don't specifically recall him saying that, but he -- he may have.
Q Okay.
A I've seen her hospital records, and I understand what he was talking about.
Q The way this e-mail reads, I'm -- I'm reading it without much context. It reads as though Dr. Schamber reported something to you, and then you reported something to Ms. Fennigkoh. Is that -- is that how you read it?
A Either that, or -- or Amber spoke with Dr. Schamber as well.

Page 212

Q Okay. Does this refresh any -- your memory about anything else that was discussed in your call with Dr. Schamber?
A I think he was the one that told me that the electrolytes -- because I don't think I saw the hospital records, at that point. He said her potassium was quite low, and that was likely the cause of her arrest. And that was something that you are not able to tell without a lab value, so it wouldn't be something that you could know.
Q The only way you could know something like, that is if you'd sent Ms. Boyer out to the hospital, right?
A If she'd had a blood test done.
Q You went to the Monroe County Jail multiple times, every week, while you worked for ACH at the Monroe County Jail, right?
A Correct.
Q You were aware that there was an emergency room and a hospital across the street from the jail; is that right?
A I was.
Q Okay. So during the -- okay. Let me strike it. During all these calls regarding Ms. Boyer on the 22nd, you knew that an emergency room was yards away

Page 213

from the jail; is that right?
MR. KNOTT: Object to form.
A Yes.
Q I'm almost done here, Ms. Pisney. All right. When -- when you were hired on at ACH, you attended a multi-day course in Peoria, Illinois; is that right?
A Yes.
Q And that was something of an orientation for new hires to ACH?
A Yes.
Q Was part of the way it was billed to you, to train you in how to function in correctional medicine, as opposed to medicine in the community?
A Yes.
MR. WEIL: Okay. I'm going to introduce -- this would be -- are we on Exhibit 31, Sydney?
COURT REPORTER: Yes.
MR. WEIL: Okay. So I'm introducing what's been marked as Exhibit 31. This was part of a larger production by ACH, that begins ACH Bates 18914, and it ends ACH Bates 18929. I'm going to write that down for my own notes here and then we'll get going.
BY MR. WEIL:
Q As I understand it from your lawyer,

Page 214

Ms. Pisney, this was among a deck of documents that you kept with you from that training, that you had when you began working at -- before you began working at ACH; is that right?

(EXHIBIT 31 MARKED FOR IDENTIFICATION)

A I assume. Yes.

Q Okay. Do you recognize -- here I'm going to blow it up. I'll take off the marginal lines. Do you recognize this document?

A It was in a bind -- a very large binder of information that we went through.

Q Okay. And this -- this particular PowerPoint says, "Introduction to Correctional Healthcare." Do you see that?

A Yes.

Q When this training was performed, do you recall how it was performed? Was this something that was handed to you, or was this done in conjunction with some sort of in-person presentation?

A Some of it was -- we didn't go through specifically, and some of it we did. I can't remember if this was one we particularly had an in-person presentation, but there were multiple presentations in those days -- those two days, I think it was.

Q There -- I saw in the production, I don't have

Page 215

it handy to pull up, but sort of an itinerary for those two days; is that right?

A Okay.

Q And when --

A That's possible. Yes.

Q Is that consistent with your recollection?

A Yes.

Q Okay. And when I -- the itinerary indicated a lot of presentations that would have the same title as what -- what's on various different PowerPoint slide decks? Is it --

A Yes.

Q Okay. Is it consistent in your recollection that those slide decks that -- whose titles also appear in the itinerary, were in-person presentations?

A I believe so.

Q Okay. Do you recall Travis Schamber presenting any topics?

A Yes. He presented many.

Q Okay. Was there any illustration, or visual media, or anything like that presented in addition to this PowerPoint, as part of these presentations?

A I don't believe so.

Q Okay. And so it would be -- you would have this PowerPoint with you, in the binder, right?

Page 216

A Yes.

Q And then there'd be -- I'm assuming there'd be -- you'd be in a room with other folks, and Dr. Schamber is maybe up in front, and he's got the same slides pulled up on some sort of a projector for everybody to see; is that right?

A Yes.

Q Okay. Do you know whether any of those meetings -- did it look to you like they were being recorded at all?

A I don't think so.

Q Okay. I went to -- I --

MR. KNOTT: I'm sorry. What exhibit is this?

MR. WEIL: This is 31.

MR. KNOTT: In terms of number.

MR. WEIL: 31, Doug.

MR. KNOTT: Thank you.

BY MR. WEIL:

Q Do you see this, "Why do you go to the doctor?"

A Yes.

Q Okay. And one of the reasons you go to the doctor is to be healthy, right? That's what you were told?

A I guess.

Page 217

Q Okay. Were you informed that inmates go to the doctor for different reasons than people in the free world?

A They have different motivations, at times.

Q Okay. Were you told that these --

MR. KNOTT: Could you give me the Bates number?

MR. WEIL: Sure, sure, sure.

MR. KNOTT: I'm just trying to catch up here.

MR. WEIL: Absolutely. Again, it's -- the starting Bates of Exhibit 31 is 18914, and the ending Bates is 18929.

MR. KNOTT: Okay. Thanks.

BY MR. WEIL:

Q Okay. So were you told that inmates go to doctors for different reasons than people in the free world?

A When they're in jail, they may see the doctor or have different motivations for seeking care than when they're on the outside.

Q Okay. And were you told that health is not the goal of an inmate who seeks medical attention in the jail?

MR. KNOTT: Object to form.

A I mean, they're not there for primary care, I

Page 218

guess, would be my understanding of what that -- what's meant by that, I guess.

Q Meaning that, ACH was training you that inmates don't go to see doctors for primary care purposes, but instead go for the purposes listed on this bullet point -- or this slide that says, "Why does the inmate seek medical attention?"

MR. KNOTT: Object. I think it misstates the document. Foundation for her personal knowledge.

A I don't specifically remember them discussing this, but this -- what I think is, this could be some of the motivations of a -- of an inmate seeking care, but...

Q Do you see -- here, I'm going to make this a little bigger here. On the next page it says, "What is your doctor's goal when he sees you in the office," do you see that?

A Yes.

Q And it says, "The doctor wants to understand what you want," do you see that?

A Yes.

Q Is that how you practice medicine, Ms. Pisney?

A Usually I ask the patient, what brings you to see me today? So that is kind of what they want.

Q Okay. Do you order -- the next line says, the

Page 219

-- if a patient says, "Well I want you to figure out what's wrong with me," is that what you try to do?

A Yes.

Q Do you think you should approach patients differently in the jail, if a patient comes to you and says, "I want you to figure out what's wrong with me?"

A No. I treat my -- the -- or the -- I treat patients and inmates the same. I would -- I think that sometimes their motivations are not always clear in jail, as they're not always clear on the outside either, so...

Q Okay. This is a "Remember, you want to be healthy," do you see that?

A Yes.

Q And "the inmate wants to be comfortable," right?

A Yes.

Q Do you believe that inmates just want to be comfortable, when they come to a doctor in the jail?

MR. KNOTT: Overly broad. Foundation. Speculation.

A I think that's one of the reasons they might see me.

Q Why -- why is that the only reason listed -- why do you think that's the only reason listed on this

Page 220

PowerPoint?

MR. KNOTT: Foundation. Speculation.

MR. MCCAULEY: Joined.

A The -- the -- you know, these PowerPoints were not the only things that were said in the orientation.

Q What was --

A There was more discussion going on.

Q Okay. Was -- do you remember anybody saying anything to say, this PowerPoint is actually wrong?

A I -- there may have been more further clarification. I don't know that they said the PowerPoint was wrong, but there was probably more discussion.

Q If you present with chest pain to a doctor, do you want the doctor to focus on what you want, or what's wrong with you?

A Usually, if I go with pain, I want the pain to go away, so that's a want. I want them to figure out why I'm having chest pain, and to do something about it.

Q Do you think a person who's in jail might want those exact same things?

MR. MCCAULEY: Object to form.

MR. KNOTT: Argumentative. Speculative. Overly broad. Answer, if you're able.

A Yes.

Page 221

BY MR. WEIL:

Q Do you think Ms. Boyer wanted to be comfortable, or do you think she wanted to be healthy, when she came complaining of chest pain?

MR. KNOTT: Foundation. Speculation.

A I -- I think she wanted someone to pay attention to her complaint, and I think we did.

Q Why do you think she wanted someone to pay attention to her complaint? Because she was uncomfortable, or because she was worried that she was sick?

MR. KNOTT: How is this not speculative? Foundation. Speculation.

A She was comfortable because that -- she was complaining of pain.

Q Okay. Do you think that her concern was that she was uncomfortable or that she might be having a serious medical issue?

MR. KNOTT: Foundation. Speculation.

A Again, that's hard to know.

Q Did ACH instruct you that it's okay to treat patients on the outside different than patients in a jail?

MR. KNOTT: Argumentative.

A There are certain things in the jail that we

Page 222

would not treat, that you might treat on the outside. Something like hepatitis C is not treated when patients are in jail, but often they are treated when they're in prison. So there are different treatment goals in jail than there are in the outside. Basically, the -- you want to keep the person as healthy as they were when they came in.

Q You were told by ACH, that ACH does not treat hepatitis C in jail?

MR. KNOTT: Foundation. Speculation. Vague. Overly broad.

A We wouldn't start treatment for hepatitis C inside jail.

Q I've just asked, did ACH -- did -- you said that -- did ACH tell you, that ACH does not treat Hepatitis C in jail?

A It's not something that -- that we would start treatment for in jail.

Q I'm asking what --

A It's a --

Q Okay.

A It's a long term chronic illness that can be treated on the outside, and it doesn't need to be emergently treated while they're in jail.

Q Ms. Pisney, I'm just asking what ACH told you.

Page 223

Did ACH tell you that they don't treat hepatitis C in jail?

A There are no strict protocols for treatment given out by ACH, each case is individual.

Q Okay. Did ACH ever tell you that they don't treat Hepatitis C in jail, regardless of what's in protocols?

MR. MCCAULEY: Did Ms. Boyer have hepatitis C? I don't remember that, so...

MR. WEIL: You can -- we've made a Monell claim about how ACH treats people in jail.

BY MR. WEIL:

Q Can you answer the question, Ms. Boyer?

A I'm Ms. Pisney.

Q Or Ms. Pisney, I'm sorry. I'm sorry.

A No. No one specifically told me that, but it's -- there are things that are not treated in jail because it's a short term incarceration.

Q You've encountered multiple people with hepatitis C in jail, and the practice has been not to treat them for hepatitis C while they're in jail; is that right?

MR. KNOTT: Object to form of the question. Assumes facts not in evidence. Misstates her testimony. Argumentative.

Page 224

A It's not relevant to this case.

MR. KNOTT: Yeah.

BY MR. WEIL:

Q I'm asking you to -- can you answer my question, Ms. Boyer? Or Ms. Pisney, I'm sorry.

MR. KNOTT: It's -- it's multiple.

A What is the question?

Q Have you encountered -- you've encountered multiple people in jail presenting with hepatitis C; is that right?

A There are inmates that I've seen in jail that have hepatitis C. Correct.

Q And the practice, as you understand it, of ACH, is not to treat those inmates with hepatitis C because they're not there for very long; is that right?

MR. MCCAULEY: Foundation. Speculation. Vague. And overly broad.

A If they were currently on treatment, when they came into the jail, that would likely be continued. But I doubt that we would start treatment while they were there.

Q Is that -- is that statement that you doubt you'd start treatment, based on your experience treating detainees in jails over the last several years?

A That's my understanding of how the short-term

Page 225

correctional care is taken care of. If they were transferred to prison, they would be treated in prison.

Q And that's -- your understanding is based on encountering multiple people with hepatitis C in jail, and seeing the treatment that they're given for that disease; is that right?

MR. KNOTT: It's asked and answered. And you just brought it around to argue with her.

A It depends on what treatment you're discussing. Are they having a complication from their hepatitis C, or are we talking about curing them of their hepatitis C? Because if they have a complication, I would treat them for that complication.

Q Okay. And if it's curing for hepatitis C?

A That's -- they had it when they came in, and it's not the jail's responsibility to treat them for hepatitis C -- for a cure.

Q Okay. And so your understanding based on the -- you told me, I'm just trying to understand where the basis of your statement that, we don't treat hepatitis C in jail, or words to that effect. I don't want to put words in your mouth, but that hepatitis C -- treatment for hepatitis C is not provided in jail. I'm just trying to understand the basis of that statement.

A There are certain things that you would not

Page 226

treat in jail. There are certain things that are not emergent, not urgent, that don't need to be taken care of when a patient is in jail. And hepatitis C would be one of those.

Q Have you been told by ACH, that Hepatitis C is not treated in jail?

MR. KNOTT: Asked and answered. Overly broad -- multiple.

A It depends on what you mean by treated.

Q Okay. And you said that it depends -- if I understand you correctly, if there's an emergent complication from hepatitis C, that would be treated. But hepatitis C itself would not; is that correct?

MR. KNOTT: Asked and answered. Vague. Overly broad. Foundation for her knowledge.

A I said that if they were on treatment when they came into jail, that treatment would continue. That if there was a complication they had from their hepatitis C, that would be treated. But we would not likely start treatment for a cure, while they were in jail.

Q What is the foundation for that statement that, "We would not likely start treatment for a cure while they were in jail"? Is that based on something you've been told? Is it based on what you've observed

Page 227

for prisoners, or jail inmates? Or is it based on any -- something else?

A It's based on my understanding, of what we treat when patients are in jail.

Q What is the basis of your understanding? That's what I'm asking.

A That's a chronic, long-term medical condition that they came in with. It's not -- it's not going to cause any urgent problem while they're in jail, and they will be released, and can be treated on the outside for their hepatitis C.

Q I understand the reasoning, but whether they're treated or not, as I understand it, you're saying, that they are not treated. And that's your experience; is that right?

MR. KNOTT: Argumentative. Multiple times, asked and answered.

MR. WEIL: I'm -- so --

MR. KNOTT: I know you want the sound bite, but you can't just keep asking the same question.

BY MR. WEIL:

Q I'm just trying to understand where she got this information from. That's all. She said that we don't treat hepatitis C in jail, she's identified two exceptions to that, whether treatment's ongoing or

Page 228

whether there's a complication. For the remainder, she said, there's no treatment. I'm just trying to understand the basis for that statement.

A It's just from my experience --

Q Okay. How many --

A -- in providing care.

Q Okay. How many -- since you started working for ACH, how many jail detains have you encountered, who have hepatitis C?

A I couldn't say how many.

Q Can you provide me an estimate?

A Maybe 20? I don't know. I have no idea.

Q Is your statement based on your experience with those 20 patients?

MR. KNOTT: What statement? Vague. Overly broad.

A I have multiple -- I have great experience treating hepatitis C on the outside. But -- and again, if I have a patient that is being currently treated with the medications to cure hepatitis C, and they have those medications, they continue on those medications. But it's not a medication I would start in jail.

Q And -- okay.

A Because I couldn't continue to follow them, once they're released from jail.

Page 229

Q Okay. Oh, I'm sorry. I still have this Exhibit 31 up. Do you see the next slide says, "What do we do when we hire a doctor?"

COURT REPORTER: You took it down.

Q Oh, I'm sorry. Did I take it down? Oh, here. You know what? There's two steps you need to do to share. Do you see that next slide, Ms. Pisney?

A Yes.

Q And, "Train the doctor in correctional healthcare," do you see that?

A Yes.

Q Did you receive training in correctional healthcare, outside of these two days in Peoria that we've been discussing?

A In discussions with Dr. Schamber, he oriented me to the Monroe County Jail. He provided any questions -- or any answers to questions that I had. So the ongoing conversations I had with him.

Q Okay. So you've had ongoing conversations with Dr. Schamber since that initial training?

A Yes.

Q But the training that you received when you get hired, when you got hired, was this two day orientation in Peoria; is that right?

MR. KNOTT: Form.

Page 230

A In relation to correctional healthcare, I had my experience, and training, and education as a nurse practitioner prior to that.

Q Here's another slide. It says, "Why the difference?" And I believe, it's like, what do we do when we hire a doctor? We train them in correctional healthcare. The next slide says, "Why the difference," do you see that?

A Yes.

Q Okay. And it says, "They want to get comfortable." Is that referring to detainees?

A That's my inference. Yes.

Q And that's to be distinguished from people in the free world; is that right?

MR. KNOTT: Foundation. Speculation.

A Sure. I'm asking what you were trained. Were you told that detainees are different than people in the free world, because they want to get comfortable, as distinguished of people in the free world?

A I -- I think the gist of what I got from the training, was that sometimes their motivations for seeking care is not straightforward.

Q Okay. That's like anybody, right?

A Yes. That -- anybody --

Q Whether they're in jail or not, correct?

Page 231

A That's true.

Q So what difference was ACH identifying with people in jail versus people in the free world?

MR. KNOTT: Foundation. Speculation.

A You have to be more alert for misuse of medication, or misuse of drugs in jail than you would on the outside, necessarily.

Q Do you -- okay. Did you ever get an indication that Ms. Boyer was seeking some sort of drug or other, when she came to you with healthcare complaints?

A I did not. I knew she was taking oxycodone in large amounts on the outside, but...

Q And that had been prescribed for her on the outside, right?

A Yes.

Q That's the information you had?

A Yes.

Q And you were trained that jail detainees want medications to handle anxiety; is that right?

A They sometimes do. Yes.

Q Okay. And is -- should that training -- this difference between jail detainees and others, were you instructed that should affect the way you perform a differential diagnosis?

Page 232

A No.

Q Okay. I'm trying to understand, did they explain why this difference was relevant, if your job is to perform a differential diagnosis?

A My -- my job is to care for the patient that's in front of me. And I treat the detainees as I would any other patient.

Q Meaning, any other patient on the outside, right?

A Yes. Correct.

Q So you're not trying to figure out what the patient wants. You're trying to figure out what's wrong with them, right?

A Correct.

Q And that's what a differential diagnosis is?

A That's part of it.

Q Okay. Do you have any understanding then, why they would -- why ACH should be describing a difference between detainees and people on the outside?

MR. KNOTT: Foundation. Speculation.

A There are some differences in correctional healthcare, than there is on the outside --

Q I -- right. I'm sorry. Go ahead.

A I think that -- like I said, the motivation can sometimes be different. But my practice was to

Page 233

treat all of my patients as the same.

Q I understand that as you were describing, detainees are in the jail for a short amount of time.

A Correct.

Q And I believe you said, that changes some of the ways you provide care for them, right?

A Yes.

Q But this difference isn't -- this, "Why the difference," slide is not describing detainees being in jail for a short amount of time. It's describing other attributes of detainees; is that right?

MR. KNOTT: Foundation. Speculation.

A Yeah. I can't say what motivated them to make this slide.

Q Okay. Fair to say that it sounds like ACH is just trying to tell you that detainees are different than people on the outside, in terms of what they seek healthcare for?

MR. KNOTT: Argumentative. Foundation. Asked and answered.

A Again, I -- I don't know their motivation for this particular slide.

Q Well, is that -- do you have any recollection of this instruction -- this orientation and what you were told?

Page 234

A Not this specific one. No. But I know that anytime you go into a talk, there are going to be more discussion than what's just strictly on the slide. They could be saying that this may be what the normal person thinks about inmates, but it's different. So I don't -- I don't remember.

Q If a normal person thought these things about inmates that are on this, "Why the difference," slide, do you think that would be fair to the detainees?

MR. KNOTT: Foundation. Vague. Overly broad.

MR. MCCAULEY: Object to form.

MR. KNOTT: Calls for speculation.

A I think everybody that goes into healthcare wants to take good care of patients, and make them comfortable, make them better, and treat them with respect. And that's what I do.

BY MR. WEIL:

Q Let's see, I may be close to done here, Ms. Pisney. You mentioned a moment ago that you recall seeing about 20 detainees who had hepatitis C; is that right?

A Maybe. I don't know that I always even knew if they had hepatitis C or not.

Q Right. You're reviewing -- when you treat detainees, you would often review their medical history;

Page 235

is that right?

A What they knew of their medical history.

Q Okay. And is the, your estimate that you saw somewhere around 20 detainees with hepatitis C, based on those encounters that you'd have with detainees, when you came to the jail and would interview them?

A Yes.

Q Okay.

A Yes. I -- I didn't see every detainee, and I saw maybe three or four detainees, every time I came.

Q Okay. And so, could it have been more than 20 detainees or less than 20 detainees that had hepatitis C, that you encountered in your time at the jail?

A Yes. Very possible. I really don't have any idea how many.

Q Do people suffering from hepatitis C often suffer, have complications from hepatitis C, as a result of that condition?

A Nope. Most of them never even know they have it.

Q Okay. But some do, correct? Because they're experiencing symptoms with hepatitis C?

A Perhaps. If it's been there for many years, they can develop cirrhosis of the liver and liver

Page 236

cancer. But that's after having had hepatitis C for several years.

Q For detainees who had developed cirrhosis of the liver, was it still the case that they would not be provided with care for hepatitis C, while they're at the jail?

MR. MCCAULEY: Object to form.

A I didn't know -- yeah. I didn't know if they had cirrhosis or not. We didn't have blood work on most patients that came to the hospital. There was nobody that I saw that was ever jaundiced. So I don't think anybody had severe liver disease, when I saw them in the jail.

Q Do you have an estimate of about how long a detainee is typically at the jail -- the jails you serve?

A It ran the gamut from, you know, some of the longest ones may have been there for a year or two. And some can be there for a day.

Q Hepatitis C can now be treated with a fairly short course of medication; is that right?

A That's correct.

Q Okay. And it lasts about -- I think about a month; is that right?

A Eight weeks.

Page 237

Q So, two months?

A Correct.

Q Okay. Notwithstanding that shorter time frame that's now available, you -- ACH didn't treat detainees with hepatitis C in jail; is that right?

MR. KNOTT: Willful misstatement of the record. Willful misstatement of what she said multiple times.

A I don't know that there's any clear instructions given us, not to treat people for hepatitis C. But again, it's a chronic illness that many people don't have any symptoms of, that takes many years to develop cirrhosis, and that patients can be treated on the outside. And when they are incarcerated for longer, they're given that option of treatment as well.

BY MR. WEIL:

Q And the reasons you've just provided, those are the reasons that ACH doesn't provide treatments for Hepatitis C in jail?

MR. KNOTT: Willful misstatement of testimony.

A Again, I never received specific instructions to not treat hepatitis C in the jail.

Q Okay. You just gave me a list of reasons or factors, why were you giving me that list of -- they're not there for a long time, it takes a while --

Page 238

A I didn't -- again, I never started treatment for anybody for hepatitis C while they were in jail. It's something that if they're released from jail, they need to continue on treatment. And I don't have the ability to follow them when they're released from jail. So I couldn't start someone on treatment, that I wasn't going to follow.

MR. WEIL: Okay. Okay. Why don't we just take a beat here, two minutes, and then I may be done.

MR. MCCAULEY: Let's take five, if you don't mind.

MR. WEIL: Absolutely, that's no problem.

COURT REPORTER: We are off the record. The time is 4:58.

(OFF THE RECORD)

COURT REPORTER: We are back on the record for the deposition of Lisa Pisney, being conducted by video conference. My name is Sydney Little. Today is March 3, 2022. And the time is 5:05pm.

BY MR. WEIL:

Q Ms. Pisney, I just have a couple more questions and I'll be done. Turning you to Exhibit 19, which we've been going over, this chest pain protocol. If you had been provided the information that's written

Page 239

in this protocol, under the S and the O letters, would you have sent Ms. Boyer to the emergency room?

MR. KNOTT: Foundation. Speculation.

A It's hard to know how that might have changed my thinking. There are a few things on here, like her medications, but they're mostly dealing with high blood pressure. And I already knew she had some issues with high blood pressure. The heart history may have changed my thinking, but I may have waited and done the same thing as I did. Say, you know, If it continues, let me know, and we'll go from there. So it's hard to know.

Q So, if you'd been provided the rest of this information at around 8:09 p.m., when the -- you see 8:09 p.m.'s written on the form there, up on the top?

A Yeah. Yes.

Q Assuming this, you recall this information was provided to you around 8:09 p.m., or thereabouts, if you'd been provided all the information that's under the S and the O on this form, you would not have attempted to rule out heart attack at that time, under the differential diagnosis; is that right?

MR. KNOTT: Foundation. Speculation.

A I think the thing that would be most concerning to me was her complaint of, "I'm not right." And specifically, I don't remember hearing that, but I

Page 240

do take complaints like that serious. And -- but again, you know, someone might say that if they're having a panic attack as well. So it's hard to know what you would do in retrospect. I could tell you what I would like to have done in retrospect, but with the information I had at the time, I do believe that I provided good care.

Q When -- we discussed hepatitis C for a bit, when someone has been ordered medication and you believe -- or have learned that they're leaving the jail soon, do you withhold ordering that prescription, if they're leaving soon?

A No.

Q Okay. I'm going to show you Exhibit 26, which is an e-mail from Amber Fennigkoh to a woman named Sarah Malloy (phonetic). Do you see that in front of you?

A I see it. But I can't read it.

Q Sure. I'm going to make it a little -- I'm just interested, this looks like somewhat -- the -- I'll say that the blackout lines on the left hand side, I understand are the name of different patients. Okay?

A Okay.

Q And they're redacted for privacy purposes. There's a patient here that says, "Saw Lisa, she ordered," and said one, continue to take -- oh, I'm

Page 241

sorry. I'm on the wrong one. This up here, "Diabetic, four times per day. Not very compliant. All orders are in. I reviewed with Lisa. Did not send any sheet to pharm, is hoping he gets out," do you see that?

A Yes.

Q Is it -- is that a familiar practice to you in terms of not ordering certain medications, because it appears that the detainee is going to be released or get out soon?

MR. KNOTT: Object. It misstates the prior testimony. And calls for speculation, as to this particular patient. And there's no evidence that there's a practice.

A Yeah. I don't even know what that means. I have no idea. I mean, I don't know what, "Diabetic, four times a day," means, "All orders are in," it says, so I don't -- I have no idea what that means.

BY MR. WEIL:

Q So this, if Ms. Fennigkoh is indicating here that medication was ordered for a person, but it was not sent to be filled at the pharmacy, as there was a hope that the person might get out. That would be a real departure from practice, as far as you know; is that right?

MR. KNOTT: Misstates the prior testimony.

Lacks foundation.

A It could mean that they have enough on hand that we don't need anymore. Sometimes we renew their prescriptions, and if we know he is going to get out, and he has enough to last until he gets out, then we might not renew it.

Q Okay. If it meant something else, that it simply wasn't ordered because he was hoping to get out -- I don't know what this means. I'm asking you. If that's what it meant, would that be inappropriate?

MR. KNOTT: You do know what it meant. Because the witness talked to you about it yesterday, she wrote it.

MR. WEIL: Doug, you don't need to coach -- you don't need to coach your witness. Okay? I --

MR. KNOTT: No. I'm astounded that you misrepresent what's happening here.

MR. WEIL: I'm asking a question. I don't -- you know --

MR. KNOTT: You --

MR. WEIL: Doug, come on -- come on. Okay?

A We would not stop a medication just because we knew that the patient was getting out. No.

BY MR. WEIL:

Q Okay. And if you did stop a medication

because a patient was getting out, that would be inappropriate, right?

A It wouldn't be something that we would do.

MR. WEIL: Okay. That is all I have right now, Ms. Pisney. Thanks very much for your time today.

THE WITNESS: Thank you.

MR. MCCAULEY: Give me about five minutes. I don't know if I'm going to have any questions. If I do, it'll be very short. So give me just a minute.

COURT REPORTER: Going off the record?

MR. MCCAULEY: Maybe five minutes, sorry. But I won't keep you long.

MR. KNOTT: Yeah. You know, it's 15 after five. We just had five minutes. All right.

COURT REPORTER: Are we going off the record? Or would you like to stay on?

MR. MCCAULEY: Yeah, we're off the record.

COURT REPORTER: Off the record, okay. Thank you. Off the record at 5:12 p.m.

(DEPOSITION CONCLUDED AT 5:12 P.M.)

CERTIFICATE OF REPORTER

I do hereby certify that the witness in the foregoing transcript was taken on the date, and at the time and place set out on the Title page here of by me after first being duly sworn to testify the truth, the whole truth, and nothing but the truth; and that the said matter was recorded stenographically and mechanically by me and then reduced to typewritten form under my direction, and constitutes a true record of the transcript as taken, all to the best of my skill and ability. I certify that I am not a relative or employee of either counsel, and that I am in no way interested financially, directly or indirectly, in this action.

SYDNEY LITTLE,
COURT REPORTER/NOTARY
COMMISSION EXPIRES: 12/09/2029
SUBMITTED ON: 03/31/2022

B

F

J